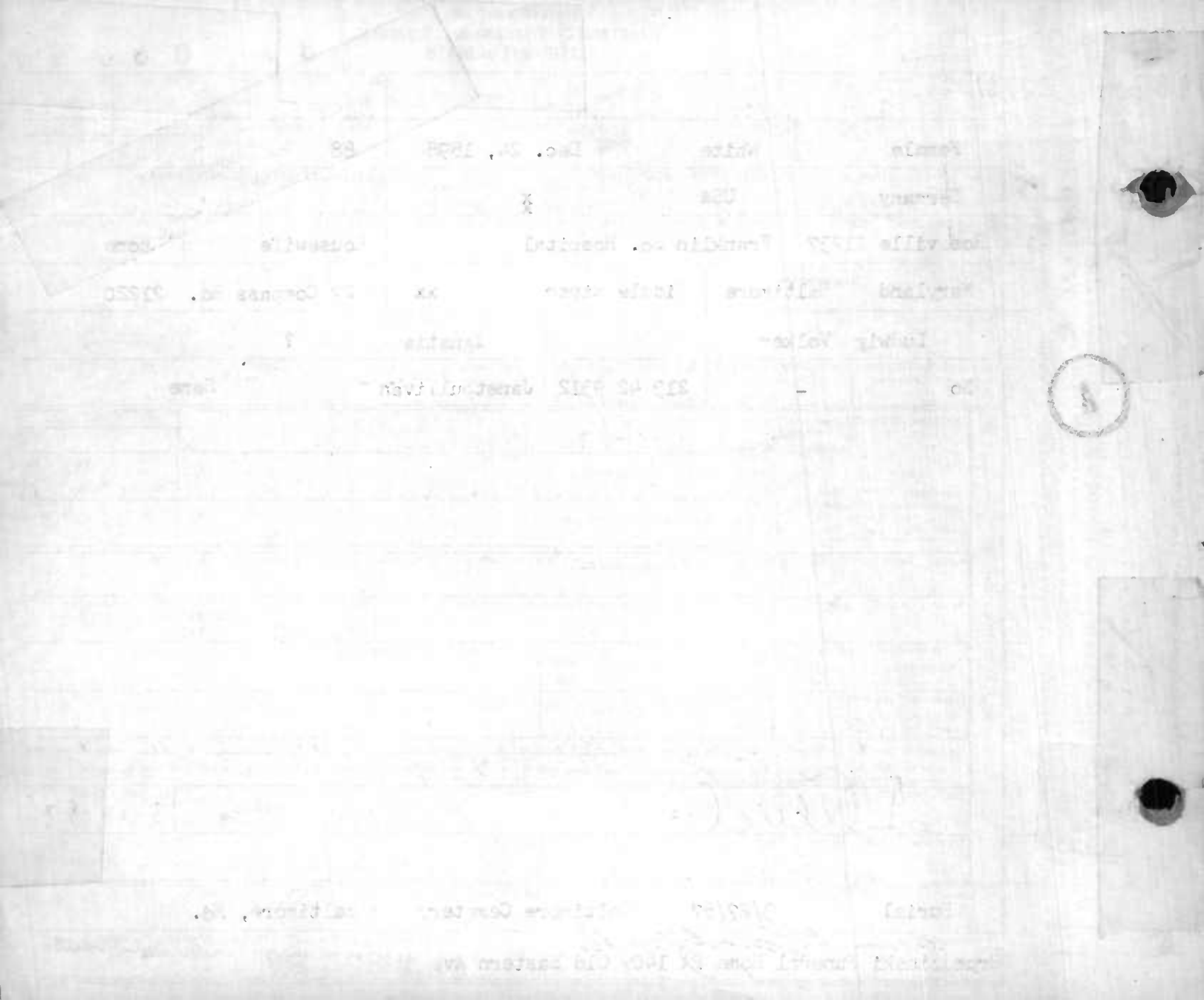


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87  
REG. NO.

06757

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (BY TYPE OR PRINT) FIRST MIDDLE LAST Eva Marie LONG			2a. DATE OF DEATH MONTH DAY YEAR March 24, 1987		2b. HOUR 11:00 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 24, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville 21237	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Middle River	
14. FATHER'S NAME FIRST MIDDLE LAST Ludwig Volker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ignatia ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -		16b. SOCIAL SECURITY NO. 213 42 9312	17. INFORMANT ADDRESS Janet Sullivan Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I (this hospital) attended the deceased from <u>March 20,</u> 19 <u>87</u> to <u>March 24</u> 19 <u>87</u> , that <u>X</u> (we) last saw the deceased alive on <u>March 24</u> 19 <u>87</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (Two (2) doctors (do not) view the body after death.)					
22b. SIGNATURE <u>Anil Minocha</u>		DEGREE		22c. DATE SIGNED 3-24-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anil Minocha, M.D.		22e. ADDRESS 9000 Franklin Square Drive, 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/27/87	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Bruzdzinski Funeral Home PA 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR MAR 26 1987		25b. REGISTRAR'S SIGNATURE <u>W. J. Davidson</u>	



048092 MAR 20

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06759

8 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD E. LOWE			2a. DATE OF DEATH MONTH DAY YEAR MARCH 20, 1987		2b. HOUR MIN. 11:15AM						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 15, 1941		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH 21234		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1852 YAKONA RD. 21234				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COORDINATOR		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE			
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1852 YAKONA ROAD 21234		
14. FATHER'S NAME FIRST MIDDLE LAST LAWRENCE LOWE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PAULINE JOHNSON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT BARBARA M. LOWE		ADDRESS 1852 YAKONA RD. 21234				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harvey Mishner</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-21-87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY MISHNER, M.D.					22e. ADDRESS WARREN RD. 666-1565						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MARCH 23, '87		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON					ADDRESS 8521 LOCH RAVEN BLVD.		25a. DATE REC'D. BY REGISTRAR MAR 23 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified orally.

BP

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044417 FEB

#18a, G 6255, 3/4/87, by Med. STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR Exam., / Gbj.  
 1- STATE REGISTRAR

REG. NO. 6760

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2d HOUR
Randy Benjamin Lowe					XX		2-15	1987		11:43
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Male	White	7-29-82		4 YRS.					2-15 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA		Baltimore County, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Randallstown		Baltimore County General Hosp.				none		---		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Baltimore		Woodstock				10037 Davis Ave.		21163
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Herbert A. Lowe					Lorraine Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS				
No				---		MD 21163 M/M Herbert Lowe 10037 Davis Ave.				

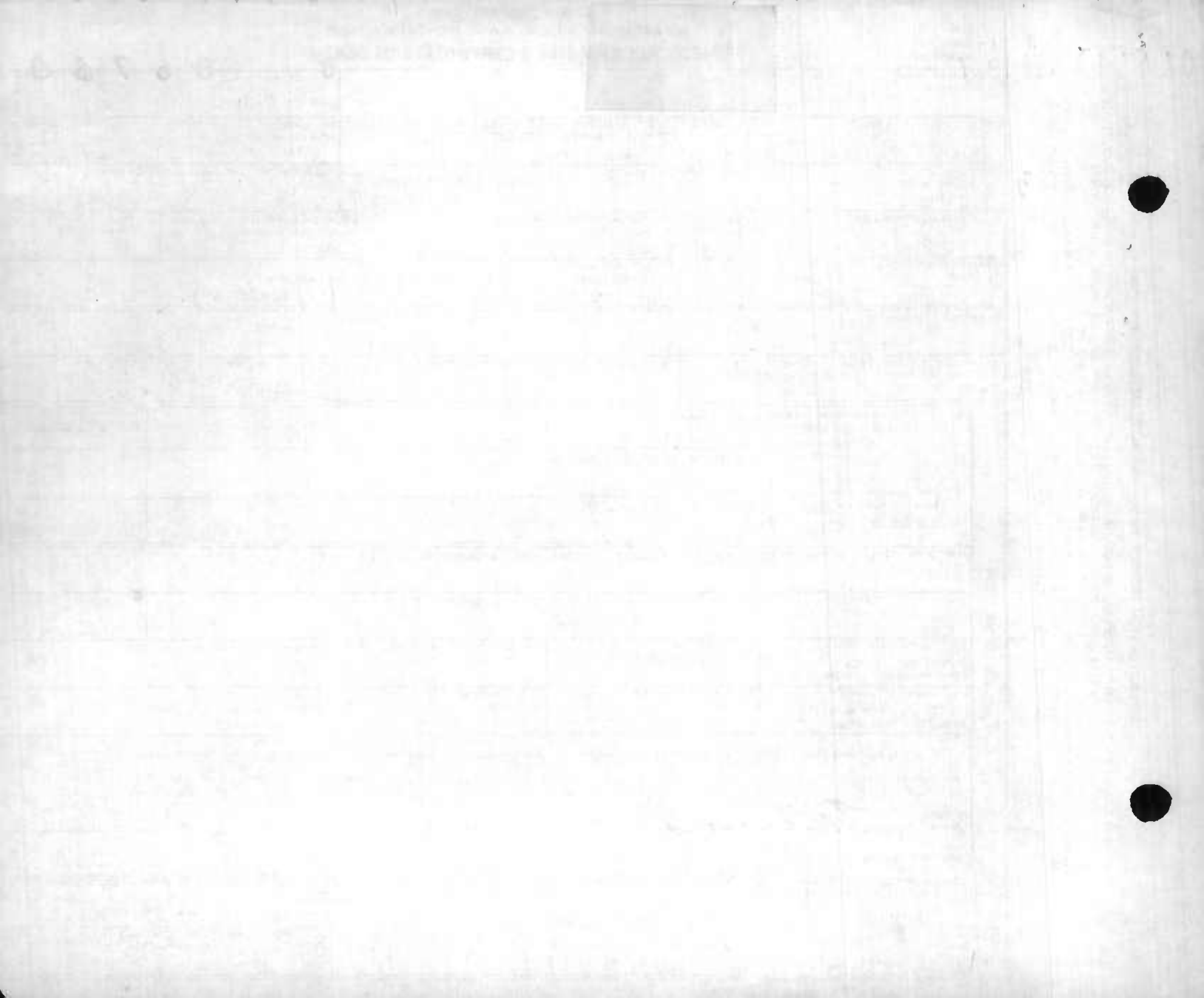
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure disorder</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(b) _____ DUE TO, OR AS A CONSEQUENCE OF		
(c) _____ DUE TO, OR AS A CONSEQUENCE OF		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <u>William M. Zane</u>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 2-16-87
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-18-87	23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Pk	23d. LOCATION CITY OR TOWN COUNTY STATE Eldersburg Carroll MD
24. FUNERAL DIRECTOR NAME Loring Byers, Funeral Directors, Inc. ADDRESS 8728 Liberty Rd. Randallstown, MD 21133		25a. DATE REC'D. BY REGISTRAR FEB 17 1987	25b. REGISTRAR'S SIGNATURE <u>John H. ...</u>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the permit to this certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 06 / 61

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST William A. Lutts		Male		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
MONTH DAY YEAR 9-10-1937		49 YRS		Maryland	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITIZEN OF WHAT COUNTRY?	
Baltimore County		U.S.A.		U.S.A.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Stella Maris Hospice		Dif. of Finance		U.S. Gov't	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore		Lutherville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
FIRST MIDDLE LAST John Albert Lutts		FIRST MIDDLE LAST Hilda Lena Kostalak		(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 12-1962	
16b. SOCIAL SECURITY NO.		17. INFORMANT		17a. STREET ADDRESS / ZIP CODE	
213-36-0214		E.M. Lutts 322 Felton Road 21093		322 Felton Road 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Pancreatic Cancer With Adenocarcinoma					
DUE TO, OR AS A CONSEQUENCE OF (b) of the Liver					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3-28-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		3-9-87 to 3-28-87		that (I) (we) last	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
Rodie Nakhuda, M.D.		Stella Maris Dulaney Valley Rd.-Towson, MD 21204		13-28-87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4-1-87		Parkwood	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212		APR - 1 1987		J. Wiedefeld	

BP

100% COTTON - FABRIC

048361 MAR 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles E. LUTZ</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 9, 1987</b>			2b. HOUR <b>11:05a</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 - 23 - 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>					13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNK</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNK</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17. INFORMANT ADDRESS <b>Stephen Bourexis Westminster, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerotic heart disease</b> <b>Chronic congestive heart failure, non-insulin dependent diabetes mellitus.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic congestive heart failure, non-insulin dependent diabetes mellitus.</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <b>February 25, 1987</b> to <b>March 9, 1987</b> , that (we) last saw the deceased alive on <b>March 9, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.										
22b. SIGNATURE <b>Meredith Drapkin</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/9/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Meredith Drapkin</b>			22e. ADDRESS <b>9000 Franklin Square Dr., Balto., 21237</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>3-20-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carroll Cremation Services</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Homestead Carroll Md</b>			
24. FUNERAL DIRECTOR NAME <b>Harry W. Hight</b>			ADDRESS <b>Sykesville, Md</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 23 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from this certificate and file it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 06163

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RAYMOND Devese LUTZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 8 87</b>			2b. HOUR <b>9<sup>25</sup> A.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 11, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>9 25</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Glyndon</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Lutz</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Devese</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT <b>Parkville</b>		ADDRESS MD <b>21234</b> <b>Mrs. Pauline Diehl 8800 Spring Rd.</b>				

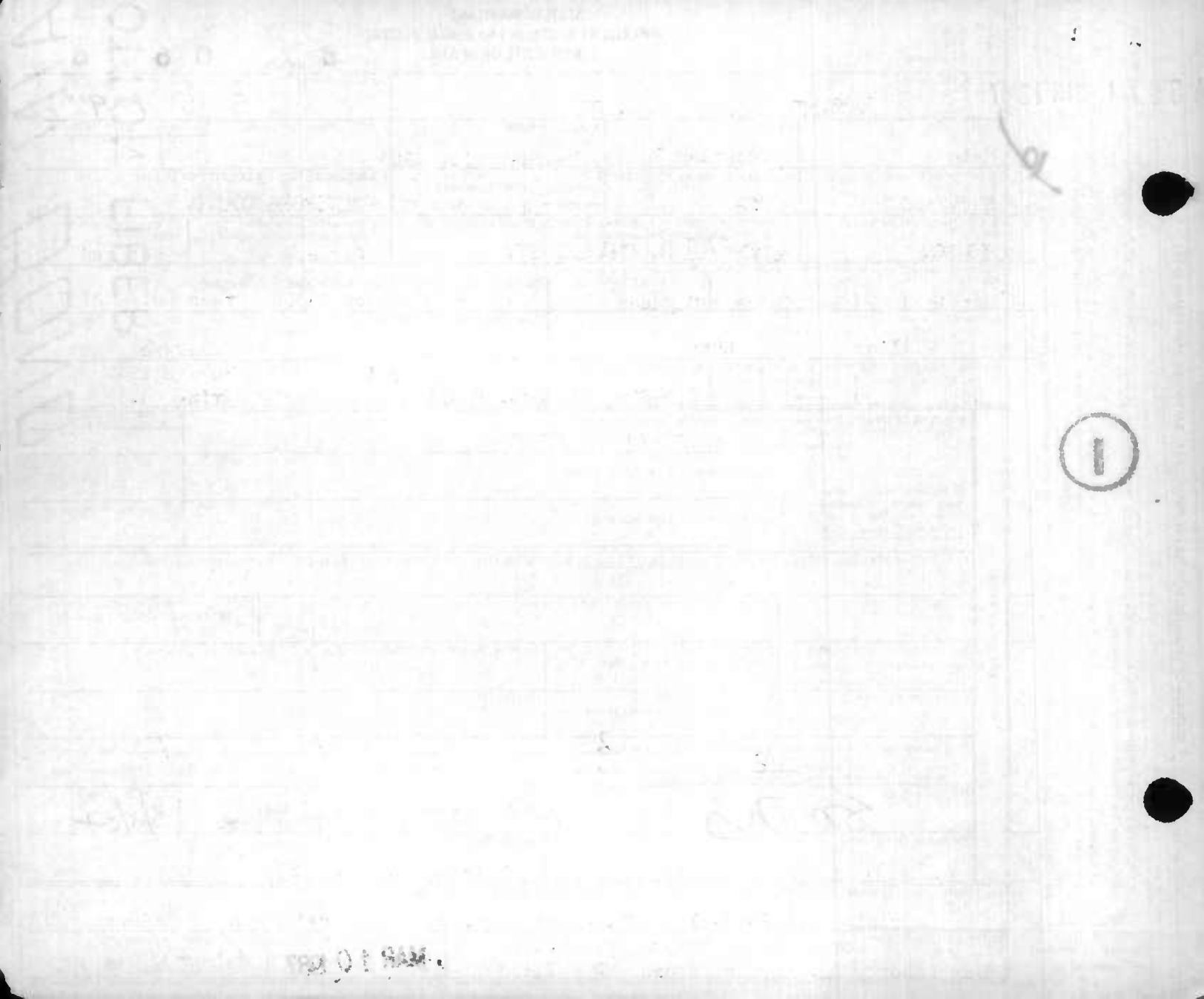
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> , 19 <b>87</b> , to <b>3/8</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>3/8</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Smith</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/8/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. SMITH M.D.</b>				22e. ADDRESS <b>6701-N. CHARLES ST</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-10-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Rd. Randallstown, MD 21133</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Lia F. ...</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		87 REG. NO. 06164									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P	
Allen Crawford MacNutt								March 12, 1987		5:30 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		October 30, 1919		76 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New Jersey		USA				Baltimore County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Sparks		1432 Belfast Road, #21152						Electrical Engineer-Can Prod.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore		Sparks				1432 Belfast Road, #21152			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Samuel Alexander MacNutt				Mabelle NMN Crawford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]				16b. SOCIAL SECURITY NO.		17. INFORMANT Wife: ADDRESS					
No				153-01-7775		Virginia C. MacNutt, 1432 Belfast Rd. Sparks					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Colon Carcinoma											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CIRCUMSTANCES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 3/12/87 to 3/12/87, that (1) (we) last saw the deceased alive on 3/12/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
H. Kim						3/12/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Charles Kim, M.D.				St. Joseph's Hospital, Towson, Maryland 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Mar. 16, 1987		Arlington Cemetery		Pennsauken, Camden Co., N.J.					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Martin D. Lawson, 10 W. Padonia Road, Timonium						MAR 13 1987		Julia Davidson-Randall			

MEDICAL CERTIFICATION

1

048543 MAR 30 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06165  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MABEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-19-87</b>			2b. HOUR <b>2 P M</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 30 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>89</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. <b>2 P M</b>		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.				
12. CITY OR TOWN OF DEATH <b>Dundalk</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Cr.-Heritage</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeping</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Md.</b>			16b. COUNTY <b>BALTO</b>		16c. CITY OR TOWN <b>Dundalk</b>		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE <b>7232 German Hill Rd. 21222</b>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Jones</b>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>			19. ADDRESS <b>Balto., Md. 21205</b>				
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			21. SOCIAL SECURITY NO. <b>218-26-2725</b>			22. INFORMANT <b>Mr. Alfonso Makell - 813 N. Broadway</b>				
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>old CVA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
24. DATE OF OPERATION <b>3/14/87</b>			25. CONDITION FOR WHICH OPERATION WAS PERFORMED			26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7232 German Hill Rd BALTO. MD</b>				
34. I certify that (I) (this hospital) attended the deceased from <b>3/14/87</b> to <b>present</b> , that (I) (we) lost saw the deceased alive on <b>3/15/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									35. SIGNATURE <b>Theo C Patterson m1)</b>	
36. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THEO. C. PATTERSON</b>			37. ADDRESS <b>7232 German Hill Rd 21222</b>			38. DATE SIGNED <b>3/19/87</b>		39. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
40. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			41. DATE <b>3/27/87</b>			42. NAME OF CEMETERY OR CREMATORY <b>MT. ZION CEM.</b>			43. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>	
44. FUNERAL DIRECTOR NAME ADDRESS <b>MARCH FUNERAL HOME 1101 E. NORTH AVE.</b>						45. DATE REC'D. BY REGISTRAR <b>MAR 26 1987</b>				

MEDICAL CERTIFICATION

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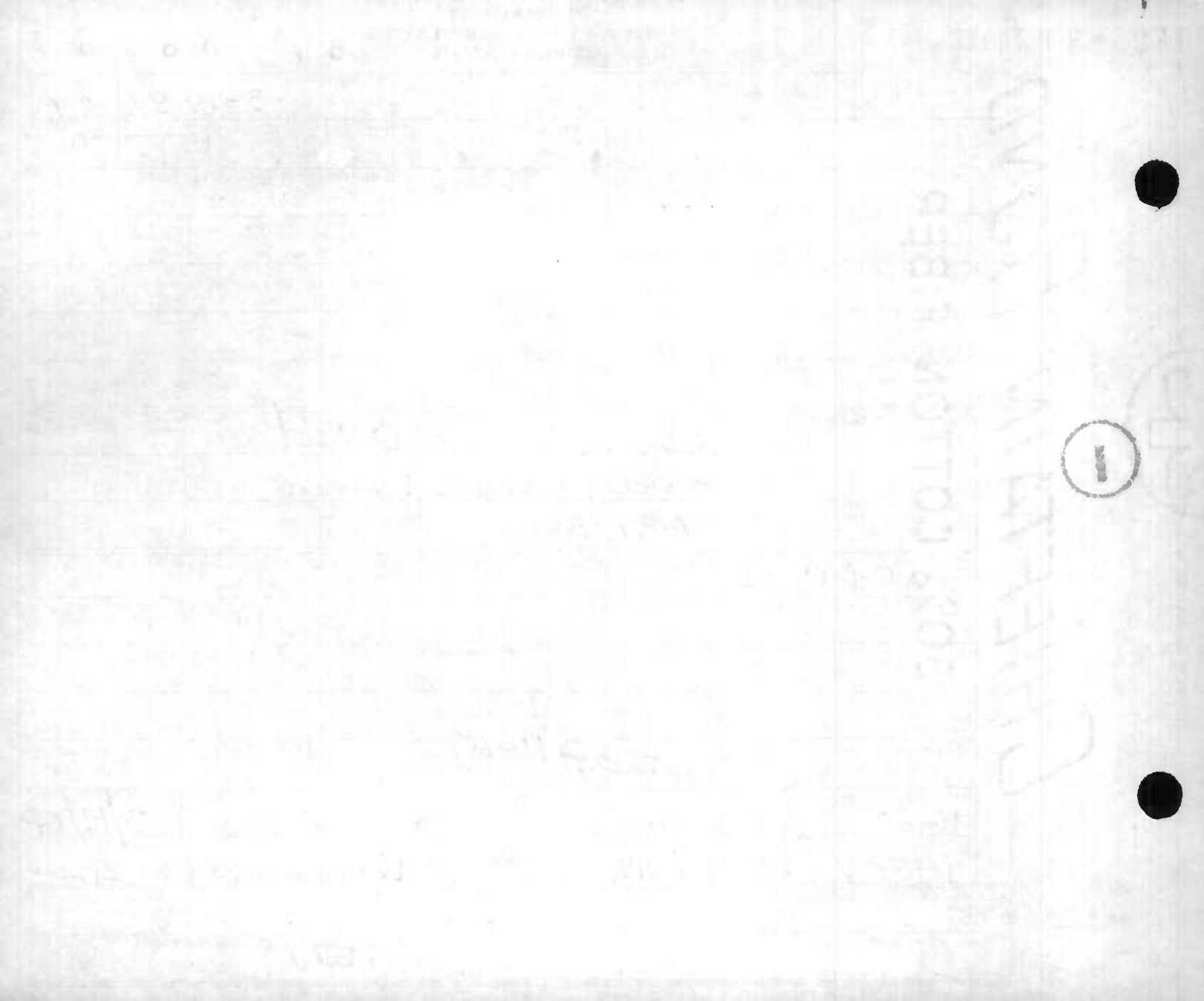
DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the above certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please return carbon copy of pages 1 and 2 should be filed with the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be detached for use as the death certificate. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 06766			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mrs. Eleanor Mallonee				2b. HOUR 4:08 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH August 18 1903 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Baltimore County General Hospital		12a. USUAL OCCUPATION (MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. Maryland		13b. Baltimore		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS / ZIP CODE 3608 Lochearn Drive 21207	
14. FATHER'S NAME MIDDLE LAST John Hoffman				15. MOTHER'S MAIDEN NAME MIDDLE LAST Agnes E. Hoffman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b. SOCIAL SECURITY NO. 217-48-8162		17. INFORMANT Mr. Wilbert Mallonee		ADDRESS 3608 Lochearn Drive Baltimore Maryland 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Myocardial INFARCTION							
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Endometrial Carcinoma							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-1-87 to 3-3-87, that (I) (we) last saw the deceased alive on 3-3-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE RAYADURG GOVINDA RAO				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYADURG GOVINDA RAO				22e. ADDRESS BALT COUNTY GENL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION Woodlawn Baltimore MD	
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, MD. 21133				25a. DATE REC'D BY REGISTRAR MAR 06 1987		25b. REGISTRAR'S SIGNATURE Julia Darden-Randall	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06767  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDRICK E. MALLONEE			7a. DATE OF DEATH MONTH DAY YEAR 3 - 10 - 87		7b. HOUR 4:15 A.M.
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 10 01 05	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS	7d. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER	12b. KIND OF BUSINESS OR INDUSTRY OIL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. CITY OR TOWN BALTIMORE	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 6101 LOCH RAVEN BLVD 21239
14. FATHER'S NAME FIRST MIDDLE LAST JOHN T. MALLONEE	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA M. SPANGLE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT APT. 312 ADDRESS MARY M. MALLONEE 21239 6101 LOCH RAVEN BLVD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PNEUMONIA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-28-87</u> to <u>3-10-87</u> , that (I) (we) last saw the deceased alive on <u>3-10-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James E. Mouldsdales, M.D.</u>		DEGREE		22c. DATE SIGNED 3/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. MOULSDALES, M.D.		22e. ADDRESS 7402 YORK RD., SUITE 200 TOWSON, MD. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MARCH 13, '87	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY		23d. LOCATION Baltimore County, MARYLAND	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON		25a. DATE REC'D. BY REGISTRAR MAR 11 1987		25b. REGISTRAR'S SIGNATURE Lidia Timoshin-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove soluble portions of page 4 and 5 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR		REG. NO. 06768							
1. DECEASED NAME (TYPE OR PRINT) <b>Zella R. MANNING</b>		20. DATE OF DEATH MONTH DAY YEAR <b>3 27 87</b>		2b. HOUR <b>1638</b> M					
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 14 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>305 E. Joppa Rd / APT 303 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis M. Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha J. Cox</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-26-7725</b>		17. INFORMANT ADDRESS <b>Rev. James D. Manning Odenton, Md. 21113</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITUS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>3/16/87</b> to <b>3/27/87</b> , that (1) (we) last saw the deceased alive on <b>3/26/87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE <b>Peter P. Stamas</b>		DEGREE <b>M</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/27/87</b>	
22d. DECEASED'S NAME (Type or Print) <b>Peter P. Stamas</b>		22e. ADDRESS <b>420 MED ARTS ALD 101 W. REARD ST.</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>3/31/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>1050 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 06169 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Alice Ann Martin</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>MARCH 25, 1987</u>			
3 SEX <u>Female</u>				4 RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>DEC 10 1914</u>	
6 AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore county</u> MD.	
10. CITY OR TOWN OF DEATH <u>Catonsville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>1115 Delong Road Apt. C</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Kennel Operator</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>CANINE</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Catonsville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>HENRY CARLBERG</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>CARRIE KISSBAUGH</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>212-22-1809</u>		17 INFORMANT <u>JACK R. DENT</u>		ADDRESS <u>R.D. 4 BERWICK, PA 18603</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Obstructive Pulmonary Disease</u> <u>WITH COP PULMONALE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2+ years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION <u>—</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>Nov.</u> , 19 <u>85</u> , to <u>March</u> , 19 <u>87</u> , that (2) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Bernard P. Farrell</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/26/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BERNARD P. FARRELL MD</u>		22e. ADDRESS <u>11055 Little Patuxent Pkwy Columbia, Md 21044</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>28 MARCH 87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PINE GROVE Com</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BERWICK COLUMBIA PA</u>	
24. FUNERAL DIRECTOR NAME <u>Slack Funeral Home</u>				ADDRESS <u>Box 268 Ellicott City, Md 21043</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 27 1987</u>	
25b. REGISTRAR'S SIGNATURE <u>Julia Decker-Badger</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please retain the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8706770

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)FIRST  
LenaMIDDLE  
M.LAST  
MASON2. DATE OF DEATH MONTH DAY YEAR  
March 21, 19872b. HOUR  
5:30p  
M

3. SEX

FEMALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH DAY YEAR  
NOV. 19, 1915

6. AGE (IN YEARS LAST BIRTHDAY)

71 YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE  
(STATE OR FOREIGN  
COUNTRY)

VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

FRANKLIN SQUARE HOSPITAL

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

MACHINE OPERATOR

12b. KIND OF BUSINESS OR  
INDUSTRY

MANUFACTURING

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
MD.13b. COUNTY  
BALTIMORE13c. CITY OR TOWN  
BALTIMORE13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒13e. STREET ADDRESS / ZIP CODE  
4301 WINTERODE WAY

21236

14. FATHER'S NAME

FIRST  
RALPH

MIDDLE

LAST  
GRANDE

15. MOTHER'S MAIDEN NAME

FIRST  
MARIE

MIDDLE

LAST  
MARCONI16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

155-07-8061

17. INFORMANT

ADDRESS

KATHRYN GABRISH (DGHTR) SAME ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebro-vascular accident

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 hours

DUE TO, OR AS A CONSEQUENCE OF

(b) Atherosclerosis

Years

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 3/21 19 87, that (I) (we) last saw the deceased alive on Feb 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

3/23/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

DR. PATRICIA DISHARON

22e. ADDRESS

513 Stamford Rd.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

BURIAL

23b. DATE

3/24/87

23c. NAME OF CEMETERY OR CREMATORY

LAKEVIEW MEM. PARK

23d. LOCATION  
(CITY OR TOWN)

BALTIMORE

COUNTY

MD.

24. FUNERAL DIRECTOR  
NAMESCHIMUNEK FUNERAL HOME, INC.  
9705 Belair Rd., Balto. Md. 21236

25a. DATE REC'D. BY REGISTRAR

MAR 24 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06771	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Alphonse A. MAY</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>March 8, 1987</u>			2b. HOUR a m <u>11:21 a</u>			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>12- 28- 1910</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.					
10. CITY OR TOWN OF DEATH <u>Rossville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Franklin Square Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Electrician</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Blumingthal</u>			
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Eastpoint</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>7250 Bridgewood Dr. 21224</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Joseph Madejski</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary Kulinski</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>216-07-9425</u>		17. INFORMANT ADDRESS <u>Josephine S. May Same as 13e</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>83</u> , to <u>1-8</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1-8</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Savinder K. Julka</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Julka</u>				22e. ADDRESS <u>2900 Dunran Road Baltimore, MD 21222</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>3-11-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>Duda-Ruck Funeral Home of DUnlak, Inc.</u> <u>7922 Wise Ave Dundalk, Md. 21222</u>						25a. DATE REC'D. BY REGISTRAR <u>MAR 12 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Landis</u>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8706172  
REG. NO C078078564

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUSSELL MAYHEW</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 20, 1987</b>		2b. HOUR <b>1:07 a m</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 16, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER, FT. HOWARD, MD.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSPECTOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CUSTOMS DEPT.</b>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1622 GRAY PLACE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>DUNDALK</b>		21222	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM MAYHEW</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH RUSSELL</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1936-1956</b>		17. INFORMANT ADDRESS <b>Mary M. Mayhew 1622 Gray Pl. Dundalk, MD 21222</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHO PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>CARDIO VASCULAR DISEASE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (this hospital) attended the deceased from <b>2/22</b> , 19 <b>87</b> , to <b>3/20</b> , 19 <b>87</b> , that (we) lost saw the deceased alive on <b>3/20</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
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23a. SIGNATURE <i>A. Ruiz</i>				DEGREE		22c. DATE SIGNED <b>3/21/87</b>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. RUIZ, M.D.</b>				22e. ADDRESS <b>VA MEDICAL CENTER, FT. HOWARD, MD. 21052</b>			

23c. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23d. DATE <b>3/22/87</b>		23e. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>		23f. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
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24. FUNERAL DIRECTOR NAME ADDRESS <b>7922 Wise Ave. Dundalk, MD Dunda-Ruck Funeral Home of Dundalk, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove columns 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

11011



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06773

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sophie B. McCoy			2a. DATE OF DEATH MONTH DAY YEAR March 5, 1987		2b. HOUR 2:00 PM						
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 23 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co., MD.					
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) College Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1503 Dunlora Rd. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST John William Ballenger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genevieve M. Moore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 46 2356		17. INFORMANT ADDRESS Mr. Wilson L. Fewster 1503 Dunlora Rd. -04							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED UNDECEASED <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 5, 19 77</u> to <u>3/5 87</u> , that (I) (we) last saw the deceased alive on <u>3/2 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>William F. Fritz</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/6/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Fritz, M.D.				22e. ADDRESS 2 W. University Pkwy, Balto. Md. 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/7/87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.				ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR MAR 10 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Tindem-Randall</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then, page 4 should be filed with the funeral director within 24 hours after death.

IMPORTANCE: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified for advice.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the remaining carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
<div style="display: flex; justify-content: space-between;"> <div> <p>FOR STATE REGISTRAR</p> <p>048295 MAR 27 1987</p> </div> <div> <p>REG. NO. 06774</p> </div> </div>											
1. DECEASED NAME (TYPE OR PRINT) <b>Florence</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 22, 1987</b>				2b. HOUR 4:54p <sup>M</sup>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 20 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Essex</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>12 Warren Road 21221</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl Griswald</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma -</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				16b. SOCIAL SECURITY NO. <b>081-30-9638</b>		17. INFORMANT ADDRESS <b>Russell McCrillis 12 Warren Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.C. Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>H/o heart block, S/P permanent pacemaker</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan 25</b> 19 <b>87</b> , to <b>Current</b> 19 <b>87</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3/8/87</b> 19 <b>87</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE <b>Naeem Gauhar</b>				DEGREE <b>Attending Physician</b>				22c. DATE SIGNED <b>3/23/87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NAEEM GAUHAR</b>	
22e. ADDRESS <b>Essex Medical Center 21221</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>3/26/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>ConnellyFuneralHome 300MaceAve.21221</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1987</b>					
25b. REGISTRAR'S SIGNATURE											

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SECTION 17-18-19



046612 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 06775

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James Gerald McGillen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 8, 1987</b>		2b. HOUR A. <b>11:37</b> M.		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 20, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Boston, Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>231 Rollingbrook Way</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer-Westinghouse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Communications</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Gerald McGillen</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eileen --- Norton</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>099-22-9783</b>	
17. ADDRESS <b>21228 Catonsville, Md.</b>		18. NAME OF SPOUSE <b>Mrs. Noel McGillen-231 Rollingbrook Way</b>		19. DATE OF DEATH <b>March 8, 1987</b>		20. HOUR <b>11:37</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*metastatic gastric cancer*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

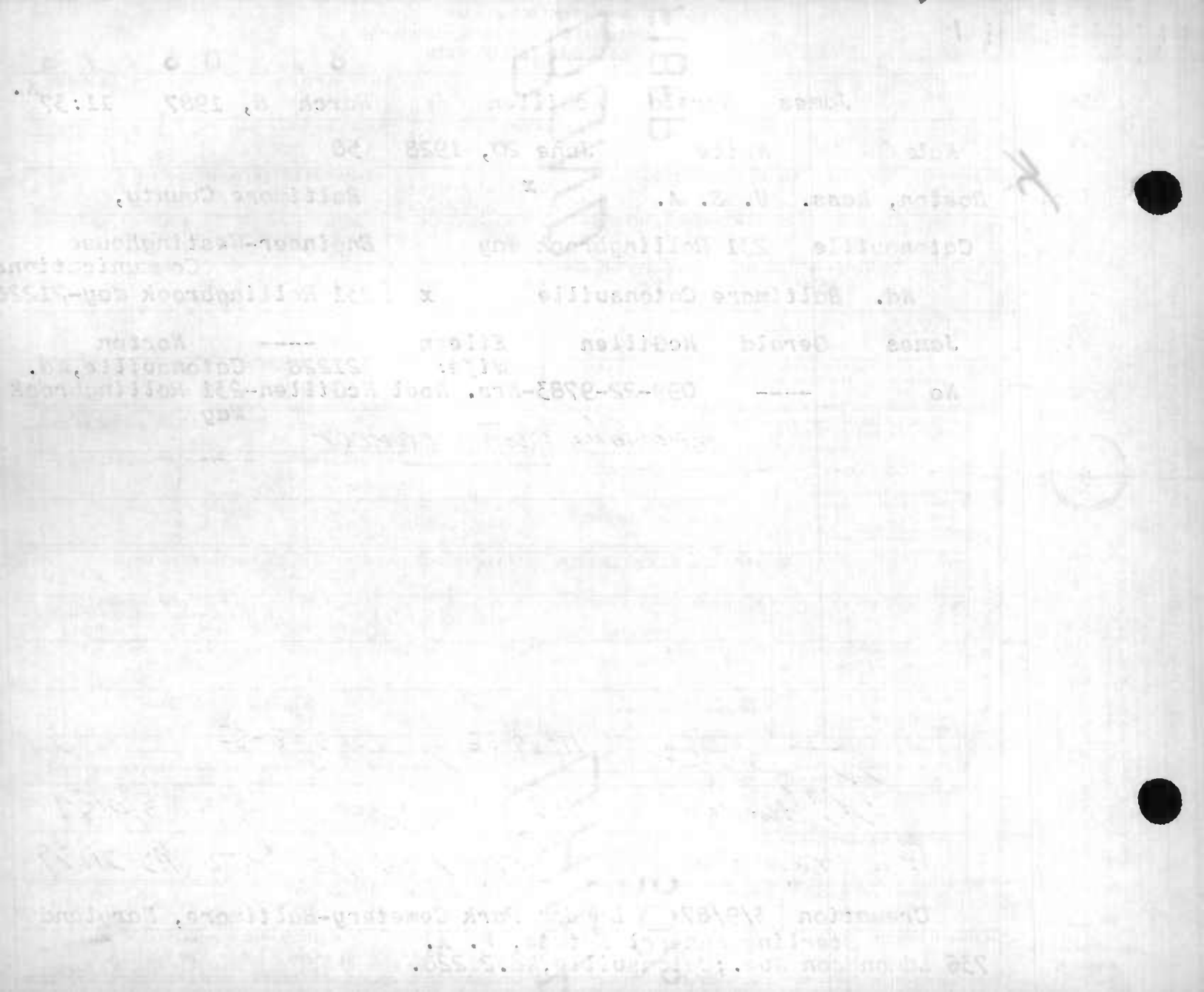
(c)

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>11-14-86</b> , 19, to <b>3-5-87</b> , 19, that (I) (we) lost saw the deceased alive on <b>3-5-87</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
27b. SIGNATURE <i>Paul Gormley</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED <b>3/9/87</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL GORMLEY</b>		27e. ADDRESS <b>900 CATON AVE BALTO MD 21229</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/9/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery-Baltimore, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Sterling Funeral Estate, P. A.</b> ADDRESS <b>736 Edmondson Ave.; Catonsville, Md. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1987</b>		25b. REGISTRAR'S SIGNATURE <i>W. J. Anderson-Randall</i>	



048654 MAR 31 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06776  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>QUEENIE MCGLONE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3. 28-87</b>			2b. HOUR M <b>M</b>	
3. SEX <b>F.</b>	4. RACE <b>B.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 23 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Garriaon</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Garrison Valley Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>A.A.Co.</b> 13c. CITY OR TOWN <b>Glen Burnie</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>6434 Miami Ave. 21061</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Rodgers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Linda Smith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>229-38-2499</b>		17. INFORMANT ADDRESS <b>Chestine Ray 6434 Miami Ave. Daughter</b>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>End Stage Amyotrophic Lateral Sclerosis</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypoxia / Hypercapnia</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Sechelya Subacute**

19a. DATE OF OPERATION <b>3-27-87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Sechelya Subacute</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-27-87</b> to <b>3-28-87</b> , that (I) (we) lost saw the deceased alive on <b>3-28-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Mohammad Aslam M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MOHAMMAD ASLAM</b>		22e. ADDRESS <b>300 - ARMY PLACE BALT. MD</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/1/87</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Norfolk Va.</b>	
24. FUNERAL DIRECTOR NAME <b>C. Wainwright</b>				ADDRESS <b>2700 Edmondson Ave.</b>		15a. DATE REC'D. BY REGISTRAR 15b. REGISTRAR'S SIGNATURE <b>MAR 30 1987</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 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384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 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634 and 635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06777	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie MC GREEVY			2a. DATE OF DEATH MONTH DAY YEAR March 31, 1987		2b. HOUR 5:35a M
3. SEX F	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 25 1896	6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY 13c. CITY OR TOWN BALTO.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 402 N. MILTON AVE. 21224		
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS HEROTEK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY SCHMIDT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-28-5864		17. INFORMANT ADDRESS Mrs. Dolores Maffioletto - 924 Elton Ave. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aplastic Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from February 11, 1987, to March 31, 1987, that (X) (we) lost saw the deceased alive on March 31, 1987, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (XXX) view the body after death.					
22b. SIGNATURE Denise Coyle		DEGREE MD		22c. DATE SIGNED 3-31-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Denise Coyle, M.D.		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-2-87		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM.	
23d. LOCATION BALTO. MD.		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Barth Miller - 7527 Harford Rd.				25a. DATE REC'D. BY REGISTRAR MAR 31 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson	



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17 FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06178  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>David P McKeever</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>87</b> HOUR <b>4:15 A.M.</b>	
3. SEX <b>White</b>	4. RACE <b>Male</b>	5. DATE OF BIRTH MONTH <b>2</b> DAY <b>25</b> YEAR <b>20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.
10. CITY OR TOWN OF DEATH <b>// Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>McKeever</b> LAST <b>McKeever</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>A.</b> LAST <b>ROSS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWII</b> <b>157-05-9098</b>		17. INFORMANT <b>Mrs. Laverne McKeever - Same as #13</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stage IV Non Hodgkin's lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Adel S. El-Hennawy</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-4-87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Adel S. El-Hennawy</b>		22e. ADDRESS <b>S J H.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>3-4-87</b>		23c. NAME OF CEMETERY OR CREMATORY
24. FUNERAL DIRECTOR NAME <b>State Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 09 1987</b>
				25b. REGISTRAR'S SIGNATURE <b>Julia Twicken-Randall</b>

MEDICAL CERTIFICATION

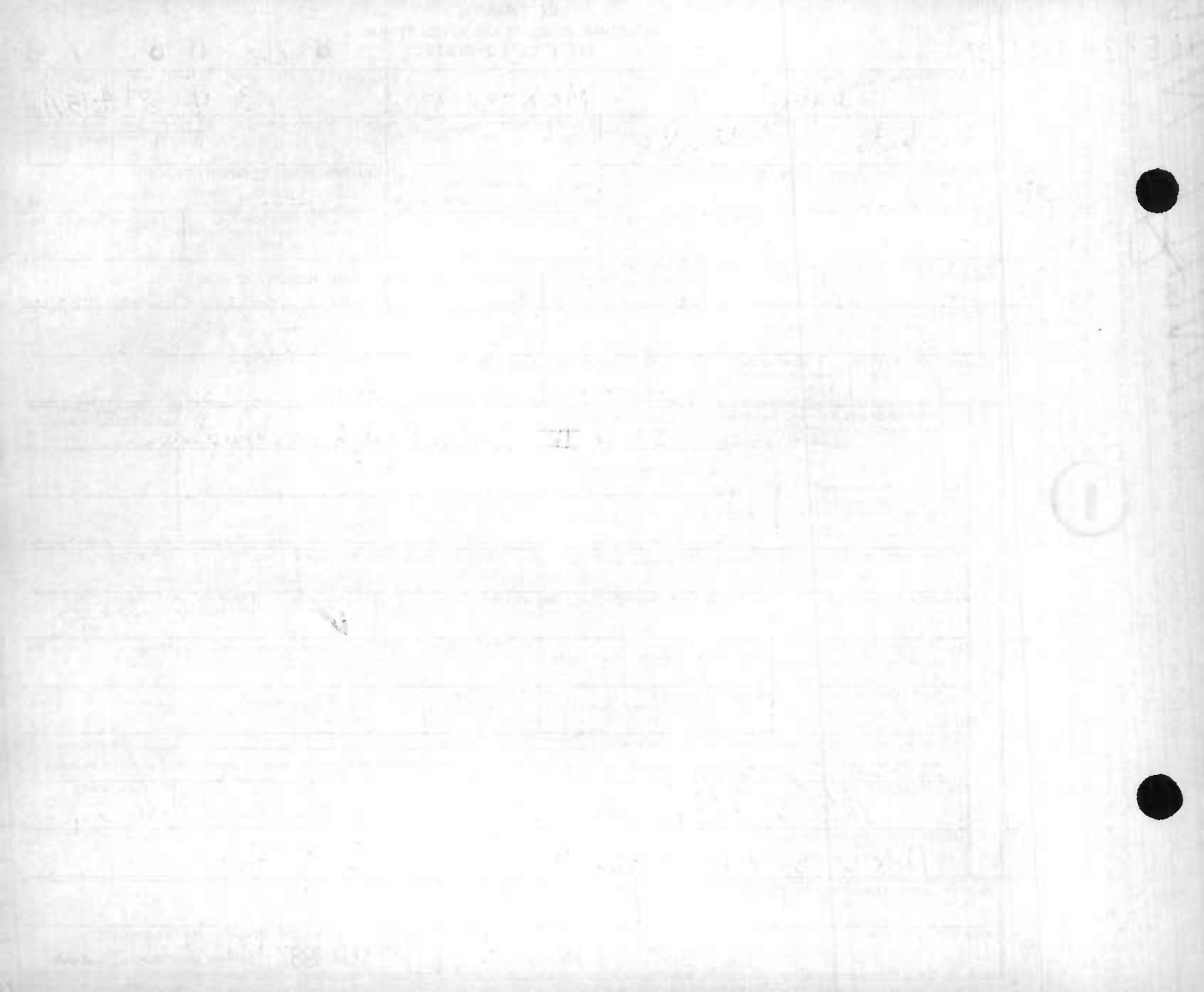
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Page 4 should be filed (within 72 hours after death) with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 checked, any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87 06779 REG. NO.		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY E. McNALLY		2a. DATE OF DEATH MONTH DAY YEAR 03-14-87		2b. HOUR 2 <sup>30</sup> PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 28 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2300 Dulaney Valley Rd. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas McNally				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Reddy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-8350		17. INFORMANT 218 N. Charles St. Suite 400 Bonnie Travieso, Balto. Md. 21201					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE WITH DEMENTIA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10 19 85, to 3/13 19 87, that (I) (we) last saw the deceased alive on 3/13 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) (the body after death).									
22b. SIGNATURE DR. I. PATCHI				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS STELLA MARIS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-17-87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D BY REGISTRAR MAR 17 1987		25b. REGISTRAR'S SIGNATURE Julia Henderson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 06780 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Lillian V. Johnson MEEKINS</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>3-10-1987</b>		2b. HOUR <b>M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 23 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. HOUR MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. Co.</b> MD.							
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1-NORTH STEAD COURT</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRUDENTIAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>INS. CO.</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>N.Y.</b>		13b. COUNTY <b>BROOKLYN</b>		13c. CITY OR TOWN <b>BROOKLYN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1-NORTH STEAD COURT 11215</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert H. Johnson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE White</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>112-18-5211</b>		17. INFORMANT ADDRESS <b>DORIS HALL - 1-NORTH STEAD COURT</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Darrell M. Gray MD.</b> DEGREE <b>MD.</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/12/87</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Darrell M. Gray MD.</b>				22e. ADDRESS <b>2329 Arundel Avenue Balto MD 21216</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-14-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DAVIS CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>IVOR</b> COUNTY <b>- VIRGINIA</b> STATE <b>- VIRGINIA</b>							
24. FUNERAL DIRECTOR NAME <b>VERNON R. BAILEY</b> ADDRESS <b>1348 N. CALHOUN ST.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

047014 MAR 11

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

999999





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

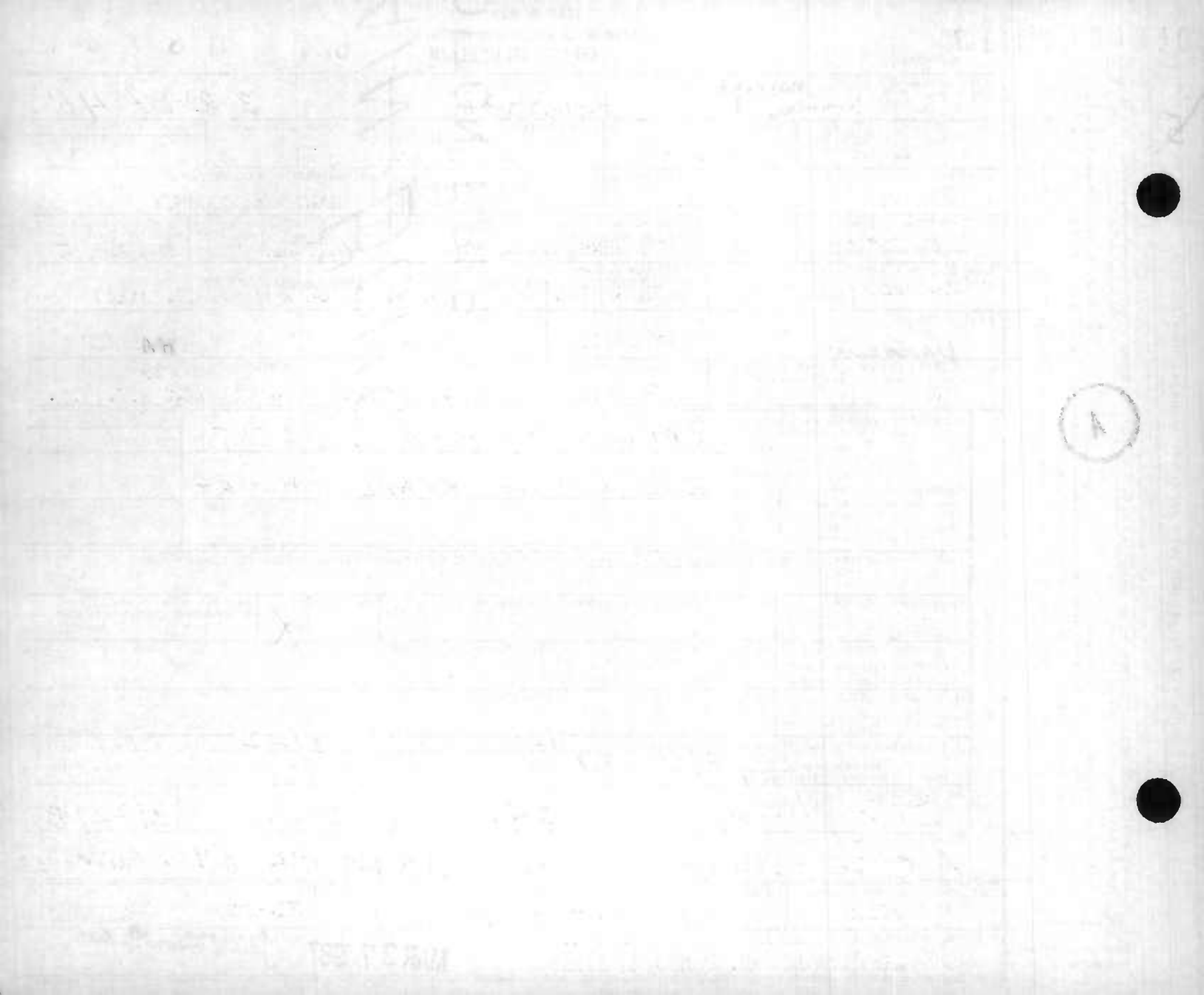
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 06781	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST MALVINE Merenstein			2a. DATE OF DEATH MONTH DAY YEAR 3-22-87			2b. HOUR 4P M		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 22, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY OR TOWN BALTIMORE 13c. CITY OR TOWN OWINGS MILLS											
14. FATHER'S NAME FIRST MIDDLE LAST UNKOWN HYMOWITZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELSIE HABAISH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-22-4248		17. INFORMANT ADDRESS 10019 LEWIS MERENSTEIN 1776 BROADWAY N.Y., N.Y.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>END STAGE RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> 19 <u>87</u> , to <u>3/22</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. Osei-Wusu</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/22/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. OSEI-WUSU				22e. ADDRESS 5710 WABASH AVE, BALTO, MD 21215							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3/23/87		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215											
25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 27 1987 <u>Julia J. [Signature]</u>											

MEDICAL CERTIFICATION



048529 MAR 30

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8706782  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva Estelle Miller			2a. DATE OF DEATH MONTH DAY YEAR 3 23 87			2b. HOUR 5 45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 28 10		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Old Court N.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY Laundromat	
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Benny Alford Malpass		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Hobbs		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-09-4237A	
17. INFORMANT		ADDRESS Patient's chart 5412 Old Court Road					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a ANEMIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN STREET COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/18/87, to 3/22/87, that (I) (we) lost the deceased alive on 3/22/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) RAMON S. PIKETTEL		22c. DATE SIGNED 3/23/87		22d. ADDRESS 7501 LIBERTY ROAD BALTO., MD. 21207	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-24-87		23c. NAME OF CEMETERY OR CREMATORY Westview PK	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		23e. DATE REC'D. BY REGISTRAR MAR 26 1987			
24. FUNERAL DIRECTOR NAME ADDRESS T-A Heckerby - ANN Md. 21201					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return card to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation or interment. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>William G. Miller</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 24 1987</b>			2b. HOUR M	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 1 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Woodlawn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5421 Gradin Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sealtest Dairy</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodlawn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5421 Gradin Ave. 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Miller</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Franey</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>		17. INFORMANT <b>Mrs. Alma E. Miller</b>		ADDRESS <b>5421 Gradin Ave. Baltimore Maryland</b>		ZIP CODE <b>21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic obstructive lung disease</b>									<b>10 years</b>
(c) <b>Arteriosclerotic Heart Disease</b>									<b>1 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>none</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>August 15</b> , 19 <b>56</b> , to <b>March 24</b> , 19 <b>87</b> , that (I) <del>last</del> saw the deceased alive on <b>March 23</b> , 19 <b>87</b> , and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>viewed</del> (did not) view the body after death.									
22b. SIGNATURE <b>Manuel Levin M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/25/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MANUEL LEVIN M.D.</b>					22e. ADDRESS <b>6101 PARK HIGTS AVE BALTO MD 21215</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-27-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, Maryland 21133</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1987</b>				
					25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06784  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN R. MISLOWSKI			2a. DATE OF DEATH MONTH DAY YEAR MARCH 22, 1987			2b. HOUR 7:28P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 6, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR INDUSTRY C. & P. TELEPHONE CO.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN RANDALLSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9614 ORPIN ROAD 21133	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH MISLOWSKI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE SEMMA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 213-20-7015		17. INFORMANT ADDRESS MRS. CAROLYN H. WALTER 8 PHEASANT RUN CT. TIMONIUM, MD 21093			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>possible CVA -</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac Arrhythmia -</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>last</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> , 19 <u>84</u> , to <u>3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>John A. F. ...</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John A. F. ...</i>					22e. ADDRESS 5550 Baltimore National Pike, Baltimore, MD. 21228				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/26/87		23c. NAME OF CEMETERY OR CREMATORY ST. ANDREWS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR LEORY M. & RUSSELL C. WITZKE 1630 EDMONDSON AVENUE, CATONSVILLE, MD, 21228					25. DATE REGD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 23 1987 <i>Julia D. ...</i>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove card from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic cause of death, medical examiner must be notified at once.



X

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked day, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8706785

1. DECEASED NAME (TYPE OR PRINT) <b>MARION Phyllis MITCHELL</b>			2a. DATE OF DEATH MONTH <b>3</b> YEAR <b>1887</b> DAY <b>21</b> HOUR <b>2:20A</b> MIN.		
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>06</b> DAY <b>11</b> YEAR <b>21</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> County MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore md</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Joseph Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>Baltimore</b> 13d. CITY OR TOWN <b>Baltimore</b>			13e. STREET ADDRESS / ZIP CODE <b>4313 Woodlea Avenue/ 21206</b>		
14. FATHER'S NAME FIRST <b>Warren</b> MIDDLE <b>Maynard</b> LAST <b>Care</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Louise</b> MIDDLE <b>Helen</b> LAST <b>Jensen</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-16-6441</b>	17. INFORMANT ADDRESS <b>20707</b> <b>Mary Cindric 6114 Goodman Road Laurel, Md.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive lung disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Adel S. El-Hennawy</b>	DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3-18-87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ADEL S. EL-HENNAWY</b>		22e. ADDRESS <b>5 JH 7620 York Road/ 21204</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>March 19, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>	23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley, Inc.</b> ADDRESS <b>Dundalk, Md. 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1987</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>	

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049498 APR - 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 06186

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Alvina Louise Moffet</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>March 31 1987</b>		2b. HOUR <b>12:50 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 3 1900</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		8. YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
7a. BIRTHPLACE (COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Augsburg Lutheran Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Perryhall</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Creamer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Torkelson</b>		17. INS. Lorraine Williams ADDRESS <b>9927 Richlyn Drive Perryhall Maryland</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>218-54-2849</b>		17. INS. Lorraine Williams ADDRESS <b>9927 Richlyn Drive Perryhall Maryland</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
**Peritonitis (3-87), cerebral thrombosis (3-87)**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to **3-31**, 19**87**, that (I) (we) lost saw the deceased alive on **3-30**, 19**87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Harold Bob MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-31-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD BOB MD</b>		22e. ADDRESS <b>7220 Park Heights 2208</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/2/887</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Overlea Baltimore Maryland</b>	
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24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133</b>		25. DATE REC'D. BY REGISTRAR <b>APR 03 1987</b>		25. REGISTRAR'S SIGNATURE <b>John Gordon-Randall</b>	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, an medical examiner must be notified immediately.

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Gardens of Eden

Funeral Directors, Inc.

1780 Broadway and Lexington, New York 10019

048933 APR 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06181

1. DECEASED NAME (TYPE OR PRINT) <b>DONALD I. MOHLER, SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 30, 1987</b>		2b. HOUR <b>5:15AM</b>										
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 14, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>YRS.</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>									
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>301 MONTROSE AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Broker &amp; Developer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>301 MONTROSE AVE. 21228</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Larsh Mohler</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lily A. Brown</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW I</b>				17. SOCIAL SECURITY NO. <b>214-22-8160</b>		18. INFORMANT <b>Mrs. Dorothy Rigg Mohler</b>	
19. CAUSE OF DEATH (Enter only one cause per part for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Strokes</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>late</b> , 19 <b>70s</b> , to <b>Present</b> , that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)															
22b. SIGNATURE <b>JAMES McPHILLIPS</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/30/87</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES McPHILLIPS</b>			22e. ADDRESS <b>22 S. Green St, Balt. 21201</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>Apr. 1, 1987</b>			23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEMT</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>						
24. FUNERAL DIRECTOR <b>STERLING FUNERAL ESTATE, P.A.</b> <b>736 Edmondson Av. Catonsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, with the State Dept. of Health and Mental Hygiene prior to burial, to the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (b), it shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR			
CARL H. MONROE			03		11		'87		11:00P		M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
MALE			White			Oct. 02 1915			71 yrs.			MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia			USA						BALTIMORE COUNTY MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON			GBMC-6701 N. CHARLES ST.						Retired			Bethlehem Steel			
13a. STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS / ZIP CODE						
Maryland			Baltimore			Dundalk YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7205 York Dr.			21222			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME									
John Monroe						Emma Clatterbaugh									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
no			224-07-9297			Stella R. Monroe			7205 York Dr. 21222						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) EXTENSIVE CVA										1 WEEK					
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										2 MONTHS					
DUE TO, OR AS A CONSEQUENCE OF															
(c) PROSTATIC CANCER WITH METASTASIS										10 YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
			HOUR A.M. MONTH DAY YEAR												
			P.M. 19												
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 02/12 19 87 to 03/11 19 87, that (I) (we) lost saw the deceased alive on 03/11 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
S. IKAI, M.D.									3/11/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
			GBMC-6701 N. CHARLES ST.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION						
Burial			3/14/87			Gardens of Faith			Baltimore, Md.						
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Connelly Funeral Home of Dundalk						MAR 17 1987			Julia S. Sander-Randall						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ENOS		LEON		MONROE				MARCH 21, 1987		4:33A <sub>M</sub>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
MALE		BLACK		AUGUST 10, 1913		73 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		U.S.A.				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VA MEDICAL CENTER				STEELWORKER		STEEL BETHELHAM			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MARYLAND				BALTIMORE				925 BONAPARTE AVENUE/21218			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
THOMAS		MONROE		NETTIE		BLUE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES		W.W. II		223 16 3194		CLINICAL RECORDS, VAMC, FORT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <u>CHRONIC AIRWAY OBSTRUCTION</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>PARAPLEGIA CORONARY ARTERIOSCLEROSIS</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>DECEMBER 11</u> , 19 <u>86</u> , to <u>MARCH 21</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>MARCH 21</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Alejandro Rivarola</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED MARCH 21, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
ALEJANDRO RIVAROLA, MD.		VAMC, FORT HOWARD, MD. 21052									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		3/25/1987		EBENEZER BAPTIST CHURCH		RICHMOND, CO. WARSAN, VA. 22572					
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
LEE FUNERAL HOME, INC. KING GEORGE, VA.		MAR 24 1987		<i>Julia Swinson-Randall</i>							

BP

CHARTERED BY THE

UNITED STATES OF AMERICA

NAVY DEPARTMENT

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NAVY DEPARTMENT  
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JUL 10 1917



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this section and page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as "yes", item 21 shows pay injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
DONNA						MONTGOMERY		3 19/87		139 pm	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
FEMALE		BLACK		10 31 48		38 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
North Carolina		USA				Balto. County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Pikesville Md		Mercy Hospital				Balto. Co. Police Dept. Crossing Guard					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		BALTO		Pikesville		YES		4752 Bonnie Beebe Rd, #08			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
UNKNOWN				UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
No		217-46-4778		John S. Montgomery		4752 Bonnie Beebe Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intracerebral + subarachnoid hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ruptured cerebral aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congested</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
G. LEE RUSSO						3/19/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
G. LEE RUSSO											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3/4/87		Crownsville Va. Com		Crownsville Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
W.C. March F/H 4300 Wabash Ave. West		MAR 23 1987		Julia Davidson-Randall							

MEDICAL CERTIFICATION

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		87 06791 REG. NO.							
1. DECEASED NAME (1st, Middle, Last)		FIRST MIDDLE LAST Emma C. MOORE		2a. DATE OF DEATH MONTH DAY YEAR March 15, 1987		2b. HOUR 9:50p M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Perry Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9651 Belair Rd. 21236	
14. FATHER'S NAME FIRST MIDDLE LAST John P. Horn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Dietz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-26-4863		17. INFORMANT Mr. Paul Moore,		ADDRESS 9651 Belair Rd. Baltimore, Md. 21236			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac and Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac and Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac and Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital attended the deceased from March 8, 1987, to March 15, 1987, that (we) lost saw the deceased alive on March 15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (do not) view the body after death.									
22b. SIGNATURE C. C. Ng, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. C. Ng, M.D.		22e. ADDRESS 9000 Franklin Square Dr., 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-19-1987		23c. NAME OF CEMETERY OR CREMATORY St. Michael Luth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Perry Hall Balto. Md.			
24. FUNERAL DIRECTOR NAME Lassah Funeral Home		ADDRESS 7401 Belair Rd		25a. DATE REC'D. BY REGISTRAR MAR 17 1987		25b. REGISTRAR'S SIGNATURE Lisa Jordan			

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FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

44-38861-1000



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HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 60322 UCBAW

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DHMH - 16 60M 7/84  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87-06192  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HILDA V. MOORE			2a. DATE OF DEATH MONTH DAY YEAR March 8, 87			2b. HOUR 4:30 <sup>P</sup> <sub>M</sub>											
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 18 97		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.							
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			10. CITIZEN OF WHAT COUNTRY? U.S.A.			11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.								
13. CITY OR TOWN OF DEATH Randallstad			14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Gen. Hospital			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			16. KIND OF BUSINESS OR INDUSTRY Federal Govt.								
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland			17b. CITY OR TOWN Carmel Sykesville			17c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			17d. STREET ADDRESS / ZIP CODE 7200 Third Ave. 21784								
18. FATHER'S NAME FIRST MIDDLE LAST Charles F. Moore			19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Reilly			20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			21. SOCIAL SECURITY NO. 220440858			22. INFORMANT Mrs. Robert Appell			23. ADDRESS West Virginia		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____																	
25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			34. LOCATION STREET CITY OR TOWN COUNTY STATE											
35. I certify that (I) (this hospital) attended the deceased from <u>March 2, 1987</u> to <u>March 8, 1987</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
36. SIGNATURE <u>Sharon Pournomard, M.D.</u>						37. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			38. DATE SIGNED 3-8-87								
39. PHYSICIAN'S NAME (TYPE OR PRINT) SHARON POURNOMARD						40. ADDRESS Balto - Co. Gen. Hospital											
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			42. DATE 03-10-87			43. NAME OF CEMETERY OR CREMATORY Zion Church Cem.			44. LOCATION CITY OR TOWN COUNTY STATE Charles Town WV								
45. FUNERAL DIRECTOR NAME Haight Funeral Home						46. ADDRESS Sykesville, MD			47. DATE REC'D. BY REGISTRAR MAR 12 1987			48. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-copy pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

6314

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
<div style="text-align: right;">8706193</div> <div style="text-align: center;">REG. NO.</div>										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Georgia MORALIS			2a. DATE OF DEATH MONTH DAY YEAR 3-31-87		2b. HOUR 725 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-28-09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker.		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3017 Royston Ave. 21214	
14. FATHER'S NAME FIRST MIDDLE LAST George Apostolides			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Demetra Arapakis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-34-2354		17. INFORMANT ADDRESS Peter Moralis - 9 Wendslow Pl., Lutherville 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>PERFORATED COLON (SIGMOID) DIVERTICULUM.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION 3-25-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ABDOMEN-PERITONITIS				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3-12-</u> 19 <u>87</u> , to <u>3-31</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3-31-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>R. DEPESTRE</u> MD				22c. DATE SIGNED 3-31-87				22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. DEPESTRE		
22e. ADDRESS BALTIMORE COUNTY GENERAL HOSPITAL										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-2-87		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR APR 1 1987		25b. REGISTRAR'S SIGNATURE <u>Frederick P. Pendergast</u>				



49254 APR - 3 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP

DHMH - 17  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06794

REG. NO.

FOR  
STATE  
REGISTRAR1- DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

MORNINGSTAR

2a. DATE KNOWN OF DEATH  
ESTIMATED  
MONTH DAY YEAR  
March 29 19872b. HOUR  
5:18 PM

3. SEX

4. RACE

5. DATE OF BIRTH  
MONTH DAY YEAR  
2 12 296. AGE  
LAST BIRTHDAY  
58 YRS.7. GENDER  
MONTHS DAYS HOURS MIN  
IF UNDER 24 HRS.2c. DATE  
PRONOUNCED  
DEAD  
March 29 19872d. HOUR  
5:18 PM7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Maryland7b. CITIZEN OF WHAT COUNTRY?  
USA8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

COUNTY

MD.

10. CITY OR TOWN OF DEATH  
TOWSON11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
ST JOSEPH HOSPITAL12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Machine Operator12b. KIND OF BUSINESS OR INDUSTRY  
Sheet Metal13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
MD STATE  
13b. COUNTY  
13c. CITY OR TOWN  
Baltimore13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐13e. STREET ADDRESS  
4901 ALSON DR 2122914. FATHER'S NAME  
FIRST MIDDLE LAST  
Paul Morningstar15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Aileen Pollard16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
No16b. SOCIAL SECURITY NO.  
215-22-253017. INFORMANT  
ADDRESS  
Elizabeth Morningstar, 4901 Alson Drive

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cerebral Anoxia  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b) ASCVD  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
Sudden  
5+ yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  
Deep Vein Thrombosis

19a. DATE OF OPERATION  
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
20. AUTOPSY?  
YES ☐ NO ☒  
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Charles F. O'Donnell TITLE (SPECIFY) Medical Examiner  
MEDICAL EXAMINER

DATE SIGNED 3/29/87

EXAMINER'S NAME (TYPE OR PRINT) Charles O'Donnell

ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial23b. DATE  
4/1/8723c. NAME OF CEMETERY OR CREMATORY  
New Cathedral Cemetery23d. LOCATION  
CITY OR TOWN COUNTY STATE  
Baltimore Maryland

24. FUNERAL DIRECTOR  
NAME ADDRESS  
Hubbard Funeral Home, Inc., 4107 Wilkens Ave.

25a. DATE REC'D. BY REGISTRAR  
APR - 2 1987

25b. REGISTRAR'S SIGNATURE  
Frederick P. ...

10050

6. 4.

10050

25 12

10050

10050



046247 MAR 9 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Katherine D. Morris					2a. DATE OF DEATH March 03, 1987		2b. HOUR 9:30 a.m.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12/19/05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 128 C Harry Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD					13b. CITY Baltimore		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME George Dimling					15. MOTHER'S MAIDEN NAME Anna Katherine Volz					13e. STREET ADDRESS / ZIP CODE 128C Harry Lane 21117	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-38-9276			17. INFORMANT Thomas D. Morris			ADDRESS 4009 Millender Mill Rd. Reisterstown MD 21136		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>again</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>again</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>hypertension - cerebral infarction</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> 19 <u>69</u> , to <u>March 3</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>David J. Hill</u> MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>David J. Hill</u>						22e. ADDRESS <u>10209 S.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 03/06/87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.			23d. LOCATION Pikesville, Baltimore, Md.			
24. FUNERAL DIRECTOR NAME <u>H. G. Eckhardt</u> ADDRESS ECKHARDT FUNERAL CHAPEL, OWINGS MILLS, MD 21117						25a. DATE REC'D. BY REGISTRAR MAR 05 1987		25b. REGISTRAR'S SIGNATURE <u>J. B. [Signature]</u>			

BP

RECEIVED  
COTTON BUDS

1000  
2000

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06796  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Cora P. Morrow</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/13/87</b>		2b. HOUR <b>4:05 A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 18 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>88 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Forest Haven Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Peeke</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>473-07-8007</b>	
17. INFORMANT ADDRESS <b>Mr. James R. Morrow Same as 13c</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer's Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-5</b> , 19 <b>85</b> , to <b>3-23</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3-3</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death)		22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold Bob M.D.</b>		22c. ADDRESS <b>7220 Park Heights Ave.</b>		22d. DATE SIGNED <b>3-23-87</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>		23b. DATE <b>3/24/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Ruck Towson Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, you must completely fill in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the registrars' report and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1, 2, 3) and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is signed, the medical examiner must be notified of death.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		87 REG. NO. 06797									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Daniel J. Moynihan								3 7 87		6:32 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		8 15 1896		90					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Massachusetts		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Dulaney Towson Nursing Home						Freight Sales		Railroad	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Balto.		Towson				119 Versailles Ct. 21204			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Dennis P. Moynihan		Margaret Mc Nerney									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
Yes		W.W.1		716-01-9706		Mrs. Helen L. Moynihan Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										2 YRS	
IMMEDIATE CAUSE (a) CHRONIC RENAL FAILURE											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
27a. SIGNATURE		DEGREE				27c. DATE SIGNED					
Nathan M. Rosenblum M.D.		MD				2-9-87					
27d. PHYSICIAN'S NAME (TYPE OR PRINT)		27e. ADDRESS									
		7600 Osler Dr. 21204									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		3/10/87		Druid Ridge Cemetery		Pikesville Balto. Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Ruck Towson Funeral Home, Inc.		21204				MAR 10 1987					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. This copy, when made carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO. 87 06198									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
AUGUST JOHN MULLER								03 10 87		3:10 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 72 HRS	
Male		White		March 15, 1908		78		MONTHS DAYS		HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		GBMC-6701 N. CHARLES ST.				Clerk - Retail		Seafood			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		424 Homeland Ave., 21212			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
? Muller		? ? ?									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
Yes		WW II		Mrs. Mary Lou Lloyd, Newark, DE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC LYMPHOCYTIC LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I (this hospital) attended the deceased from 02/25, 19 87, to 03/10, 19 87, that (I (we) lost saw the deceased alive on 03/10, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) did not view the body after death.											
22b. SIGNATURE		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		22e. DATE SIGNED					
Kelly MD		T. KELLY, M.D.		GBMC-6701 N. CHARLES ST.		3/10/87					
22a. SIGNATURE		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		22e. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE			
Burial		3/13/87		Ayers Chapel		White Hall,		MD			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212											

MAR 11 1987



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove early papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

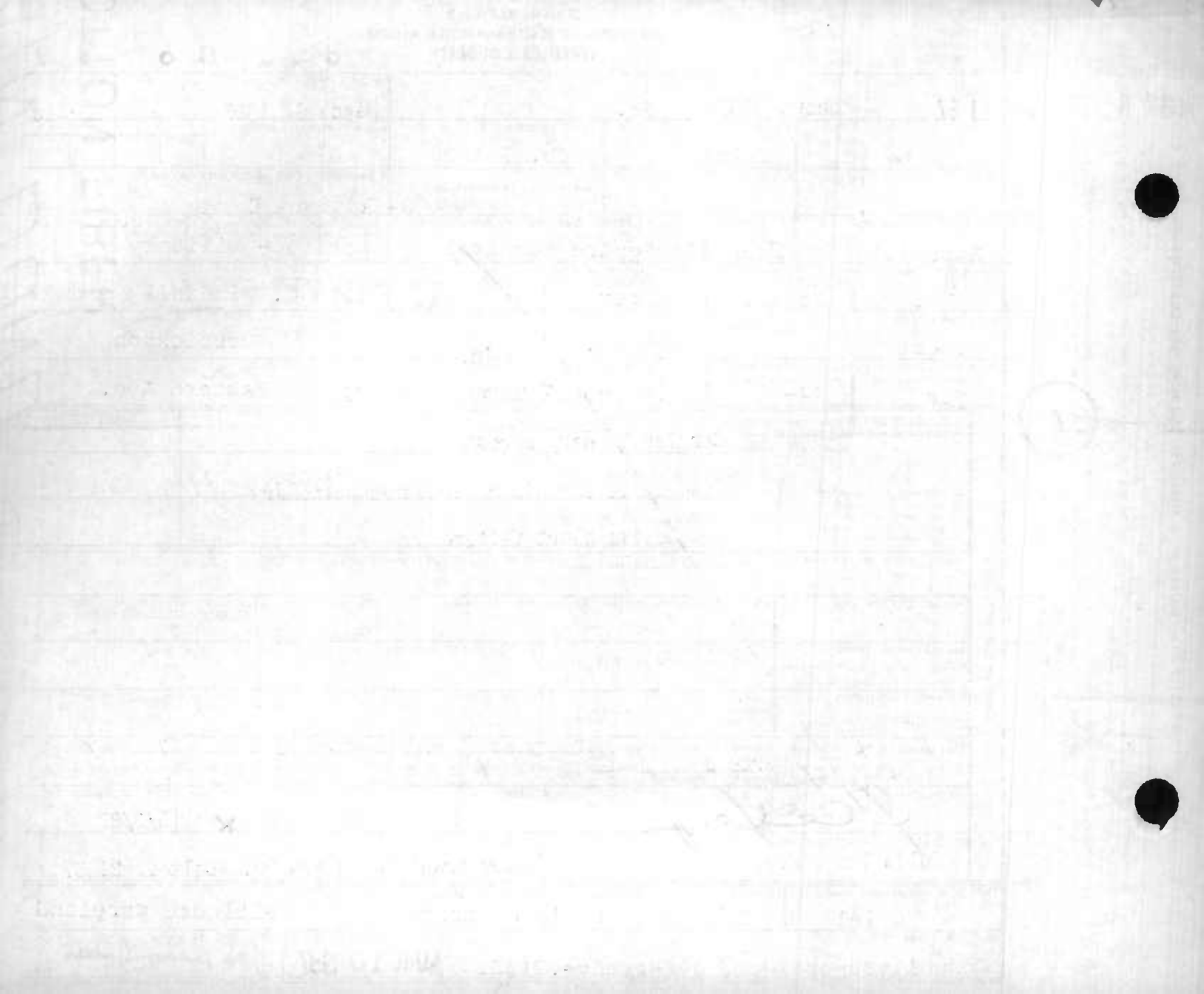
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 06199

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert MYERS Jr.			2a. DATE OF DEATH MONTH DAY YEAR March 3, 1987		2b. HOUR 10:31 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 7 1920	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired- Military		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Robert Myers Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Derrickson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 44-64	17. INFORMANT ADDRESS Timothy Knepp 814 Eastern Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) End stage chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from February 25, 1987, to March 3, 1987, that (X) (we) last saw the deceased alive on March 3, 1987, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Julian Tang</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julian Tang, M.D.		22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/6/87	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ConnellyFuneralHome		ADDRESS 300MaceAve.21221		25a. DATE REC'D. BY REGISTRAR MAR 10 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Denson-Randall</i>

BP



048830

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REC. NO. 06800

1. DECEASED NAME (TYPE OR PRINT) <b>Edna C. Nauman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 29, 1987</b>		2b. HOUR M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 29 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD	
10. CITY OR TOWN OF DEATH <b>Middle River 21220</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>101 Lariat Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK, OR MOST OF WORKING LIFE) <b>Clerk</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Middle River</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. FATHER'S NAME FIRST MIDDLE LAST <b>George Blume</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO, OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213 28 2806</b>	17. INFORMANT <b>Christian Nauman, Husband</b>		ADDRESS <b>Same</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9/85 - 3/87</b>
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/85</b> to <b>MARCH</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>FEB</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.					
22b. SIGNATURE <b>Henry Bert Holland</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3.30.87</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HENRY BERT HOLLAND</b>		22e. ADDRESS <b>600 N. WOLFE ST TOWNS HOPKINS ONCOLOGY CTR BALT. MD.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>3/31/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

March 29, 1987

John D. Brown

Dec. 29 1986

John D. Brown

John D. Brown

John D. Brown

John D. Brown

John D. Brown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06801	
1. DECEASED NAME (TYPE OR PRINT) <b>SADIE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3-22-87</b>	
3. SEX <b>female</b>		4. RACE <b>caucasian</b>		2b. HOUR <b>2:06p</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>1-11-08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH <b>Baltimore Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN NURSING CENTER-HERITAGE</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>			
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE <b>3227 O'Donnell Street 21224</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Barszkiewicz</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Pokonski</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-52-2352</b>		17. INFORMANT ADDRESS <b>Agnes Isaac 3227 O'Donnell Street 21224</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG (Rt)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Old Cerebrovascular Accident.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 year.</b> <b>4 year.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerotic cardio vascular disease.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2/27/87</b> P.M. 19 <b>87</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>2/27/87</b>	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3/22/87</b>		22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>3/22/87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Harjit Singh</b> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>3/23/87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARJIT SINGH M.D.</b>		22e. ADDRESS <b>5507-E Ritchie HWY, BALTIMORE, Md. - 21225</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-25-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Md.</b>		24. FUNERAL DIRECTOR NAME <b>Charles S. Zeiler &amp; Son Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1987</b>	
25b. REGISTRAR'S SIGNATURE		25c. ADDRESS <b>901 S. Conkling St.</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 06802		
1. FOR STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
CEVAL AARON NEAL								3 26 87			12:55PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		12 4 1899		87 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Kentucky		U.S.A.				Baltimore County MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Arbutus		921 Leeds Avenue				Welder			B&O Railroad			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland		Baltimore		Arbutus				921 Leeds Avenue 21229				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Ora Sanders Neal					Lily Ray							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO					705-10-0910		Ceval Llyod Neal 2914 Collins Ave. 20902					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <i>Metastatic Small cell Ca to lung</i>										9-19-87		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 <i>70</i> to <i>Feb 12</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>Feb 12</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
<i>Alexandro Mejia</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			3/26/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
Alexandro Mejia MD						405 Frederick Rd Catonsville 21228						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			3/28/87		Loudon Park Cemetery			Baltimore Maryland				
24. FUNERAL DIRECTOR NAME						24a. DATE REC'D. BY REGISTRAR			24b. REGISTRAR'S SIGNATURE			
Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						21229			MAR 27 1987 <i>Julia Davidson-Parker</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits require coroner's orders. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 12 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

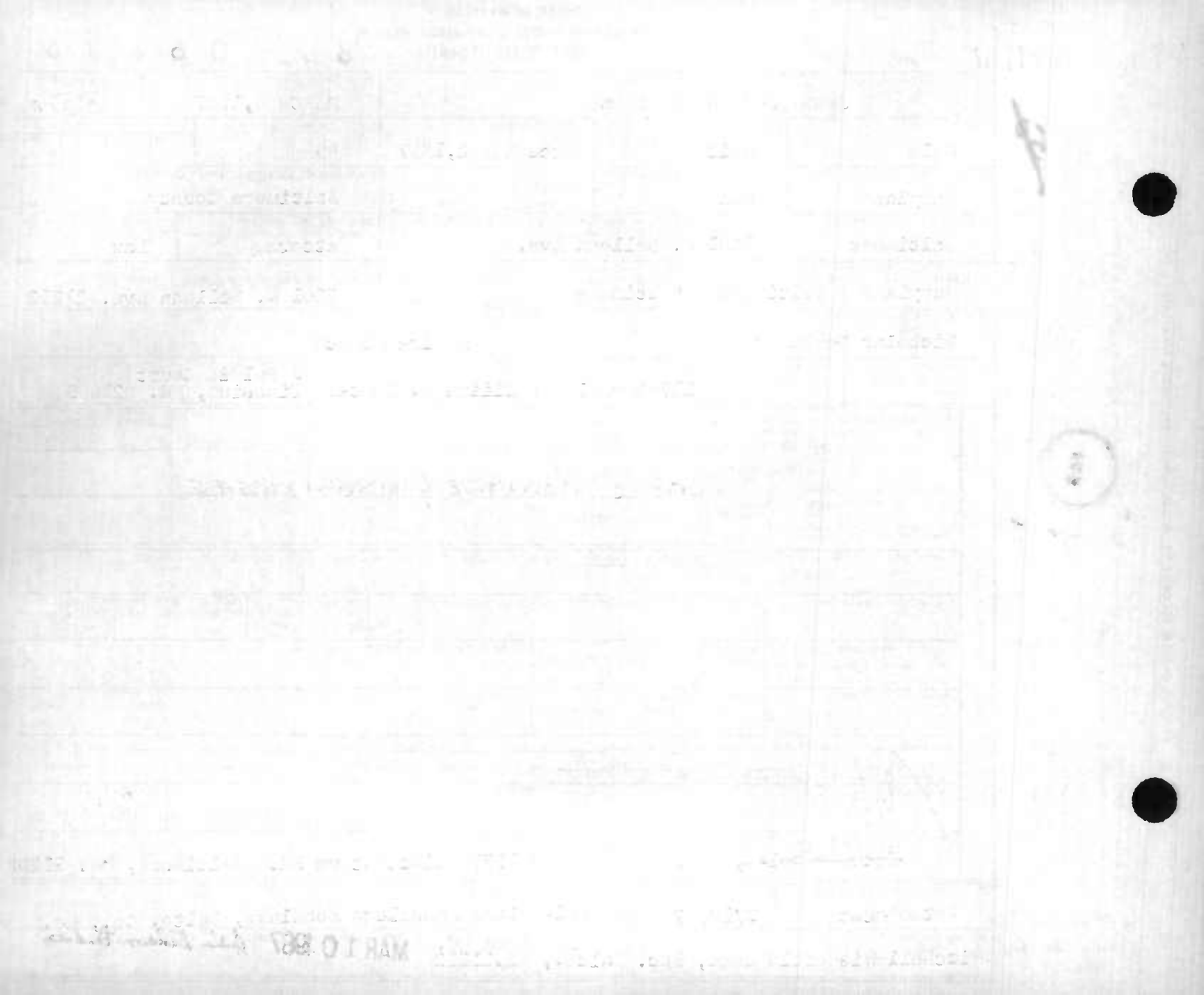
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06803

1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN JOSEPH NEUBAUER				MARCH 6, 1987				8:20 PM			
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 2, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7201 W. Bellona Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Law			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7201 W. Bellona Ave. 21212	
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Neubauer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Klaack							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-26-9976		17. INFORMANT ADDRESS Elaine M. Porter 3 Belden Court Timonium, Md. 21093							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/9/87			
22d. PHYSICIAN'S NAME (PRINT) Peter Orsulan, M.D.				22e. ADDRESS 1777 Reisterstown Rd. Baltimore, Md. 21208							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 3/10/87		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto., Co., Md.					
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.				ADDRESS 6500 York Rd. Balto., Md. 21212		25a. DATE RECEIVED BY REGISTRAR MAR 10 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 0 6 8 0 4

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Mildred		Lee		Nitzel		3/4/87		8:40pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
Female		White		October 5, 1907		79		YEARS MONTHS DAYS HOURS MINS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. UNDER 2 YEARS	
Maryland		USA				Baltimore County		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. UNDER 3 YEARS	
Essex		509 Riverside Road		Sales		Dorothy Shop		MONTHS DAYS HOURS MINS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		14. UNDER 4 YEARS	
13a. STATE				13b. COUNTY		204 N. Marlyn Ave. 21221		YEARS MONTHS DAYS HOURS MINS	
Maryland				Baltimore					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		16. ADDRESS		17. ZIP CODE	
FIRST MIDDLE LAST				FIRST MIDDLE LAST		21162			
Louis				Dellinger		George H. Nitzel, Jr.		5205 Bangert St.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		215-22-3662		George H. Nitzel, Jr.		Metastatic Small Cell Cancer			
						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE					
				February 19 87					
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
above, (I) (we) (did not) view the body after death.		Myo Thant				3/5/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Myo Thant									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
Cremation		3-6-87		Westview		Baltimore Maryland			
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE					
Duda-Ruck Funeral Home of Dundalk		MAR 00 1987							
7922 Wise Ave. Dundalk, MD 21222									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene in jury, burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

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2000-2001-2002

2000-2001-2002



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove Cariboo papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06805

1. DECEASED NAME (TYPE OR PRINT) <b>Courtney E. Norford</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3/3/87</b>		2b. HOUR <b>8:10 PM</b>	
3. SEX <b>M</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 8 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO County</b> MD.	
10. CITY OR TOWN OF DEATH <b>21234</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley View Nsg Home</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ADJUSTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	
13c. CITY OR TOWN <b>21204</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>500 VIRGINIA AVE. 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES M. NORFORD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADA RADCLIFFE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II 213-01-9001</b>		17. INFORMANT ADDRESS <b>JACQUELINE L. BILLINGS ELICOTT CITY, MARYLAND 21043</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Seizures</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>6/14/1985</b> to <b>3/3/1987</b> that (I) (we) last saw the deceased alive on <b>3/2/1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Vuong Nguyen</b>		22c. DATE SIGNED <b>3/4/87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VUONG NGUYEN</b>	
22e. ADDRESS <b>6331 Belair Rd Balto 21206</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>MARCH 5, '87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD</b>					
24. FUNERAL DIRECTOR NAME <b>WILLIAM E. JOHNSON</b>		24b. ADDRESS <b>8521 LOCH RAVEN BLVD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 04 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Lelia Truitt-Rodgers</b>					

BP \_\_\_\_\_



Handwritten notes and scribbles on lined paper, including the word "BROOKLYN" and various dates.

2/15/81

BROOKLYN

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2/15/81

046057 MAR-5197

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06806  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles E. Norris Sr.			2a. DATE OF DEATH MONTH DAY YEAR February 28, 1987		2b. HOUR 8:30 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 8 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 211 Oak Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) The Arundle Company		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY Balto.	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles I. Norris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Ridgell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 213-20-9326		17. INFORMANT ADDRESS Marguerite Norris 211 Oak Ave. 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Failure.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to liver.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the Bladder.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Eleo-hop. Perilop Hernia.</u>					
19a. DATE OF OPERATION Sept 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED for Cancer of Bladder		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> 19 <u>84</u> , to <u>Feb 28</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Feb 28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>E. A. Bohorquez</u>		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Bohorquez		22e. ADDRESS 7401 OSKER DRIVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/3/87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto. Md.					
24. FUNERAL DIRECTOR NAME Connelly Funeral Home		ADDRESS 300 Mace Ave. 21221		25a. DATE REC'D. BY REGISTRAR MAR 04 1987	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition, the medical examiner must be notified of same.

BP

100-10000



100-10000

20% Cotton

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pearl T Norris			2a. DATE OF DEATH MONTH DAY YEAR 3 7 87		2b. HOUR 4:15A <sup>MD</sup>
3 SEX Female	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 9 29 02		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Towson			MD.		
10. CITY OR TOWN OF DEATH Baltimore MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) Joseph Hosp		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STREET ADDRESS / ZIP CODE 1200 Bush Rd/Abington 21009					
14. FATHER'S NAME FIRST MIDDLE LAST Unkn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Meekins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-44-3131		
17. INFORMANT Leroy Williams			ADDRESS 2722 E. Federal St.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis and Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Multiple myeloma DUE TO, OR AS A CONSEQUENCE OF (c) and Granulocytopenia.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE Adel S. EL-HENNAWY MD				22c. DATE SIGNED 3-7-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS S J H	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/11/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR MAR 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

MAR 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. This permit gives carbon papers; Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		87		06808		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Freda				OBERENDER		March 17, 1987		2:50 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
FEMALE		WHITE		6 MONTH 2 DAY 1897		89 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
GERMANY		USA				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ROSSVILLE		FRANKLIN SQUARE HOSPITAL				Coretier		Chas. St. Corset	
13a. STATE				13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MARYLAND				BALTIMORE				13e. STREET ADDRESS / ZIP CODE	
						29 E. Elm Avenue		21206	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Frederick August Oberender				Augusta Baetz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No				214-01-1850		Mrs. Donald Seyboth 4 New Forest Ct. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Anoxic Encephalopathy</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Acute myocardial Infarction complicated with</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>congestive heart failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>March 9</u> , 19 <u>87</u> , to <u>March 17</u> , 19 <u>87</u> , that (we) lost the deceased on <u>March 17</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>Alfonso Ruiz MD.</u>								March 17, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
<u>Alfonso Ruiz MD.</u>				9000 Franklin Square Drive, 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3-20-87		Moreland Memorial Pk.		Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lassahn Funeral Home				7401 Belair Rd. BALTO MD 21236		MAR 10 1987		<u>John William B. Lee</u>	

MAR 10 1987





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please send pages 1, 2, 3, 4, and 5 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified of case.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR  
XC 29632312

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
WILLIAM EMMET O'BRIEN			MARCH 14, 1987			6:05 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE	WHITE	DECEMBER 7, 1919	67 YRS			MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH					
NEW YORK	U.S.A.		BALTIMORE COUNTY MD					
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			14a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			14b. KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD	VA MEDICAL CENTER			SFC Ret.			US ARMY	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			16. INSIDE CITY LIMITS?			17. STREET ADDRESS / ZIP CODE		
15a. STATE 15b. COUNTY 15c. CITY OR TOWN			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			489 BRUCE AVENUE 21113		
16. FATHER'S NAME			17. MOTHER'S MAIDEN NAME					
WILLIAM EMMET O'BRIEN			ROSE WERNER					
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. SOCIAL SECURITY NO.			19. INFORMANT ADDRESS		
YES VIET NAM			073 16 2606			Cristine O'Brien # 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE								
DUE TO, OR AS A CONSEQUENCE OF								
(b) ASPIRATION PNEUMONIA								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
DIABETES MELLITUS								
19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 3, 19 87, to MARCH 14, 19 87, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on MARCH 14, 19 87, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
Marcia Kane MD						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		03/14/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
MARCIA A. KANE, M.D.						VA MEDICAL CENTER, FORT HOWARD, MD 21052		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation			3-18-87		Westview Pk.		Baltimore Md.	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
T.A. Hardesty Annapolis Md. 21401						MAR 19 1987		

MEDICAL CERTIFICATION

DEPT. OF JUSTICE

DO NOT WRITE  
ON THIS SIDE

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210

048642 MAR 31

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

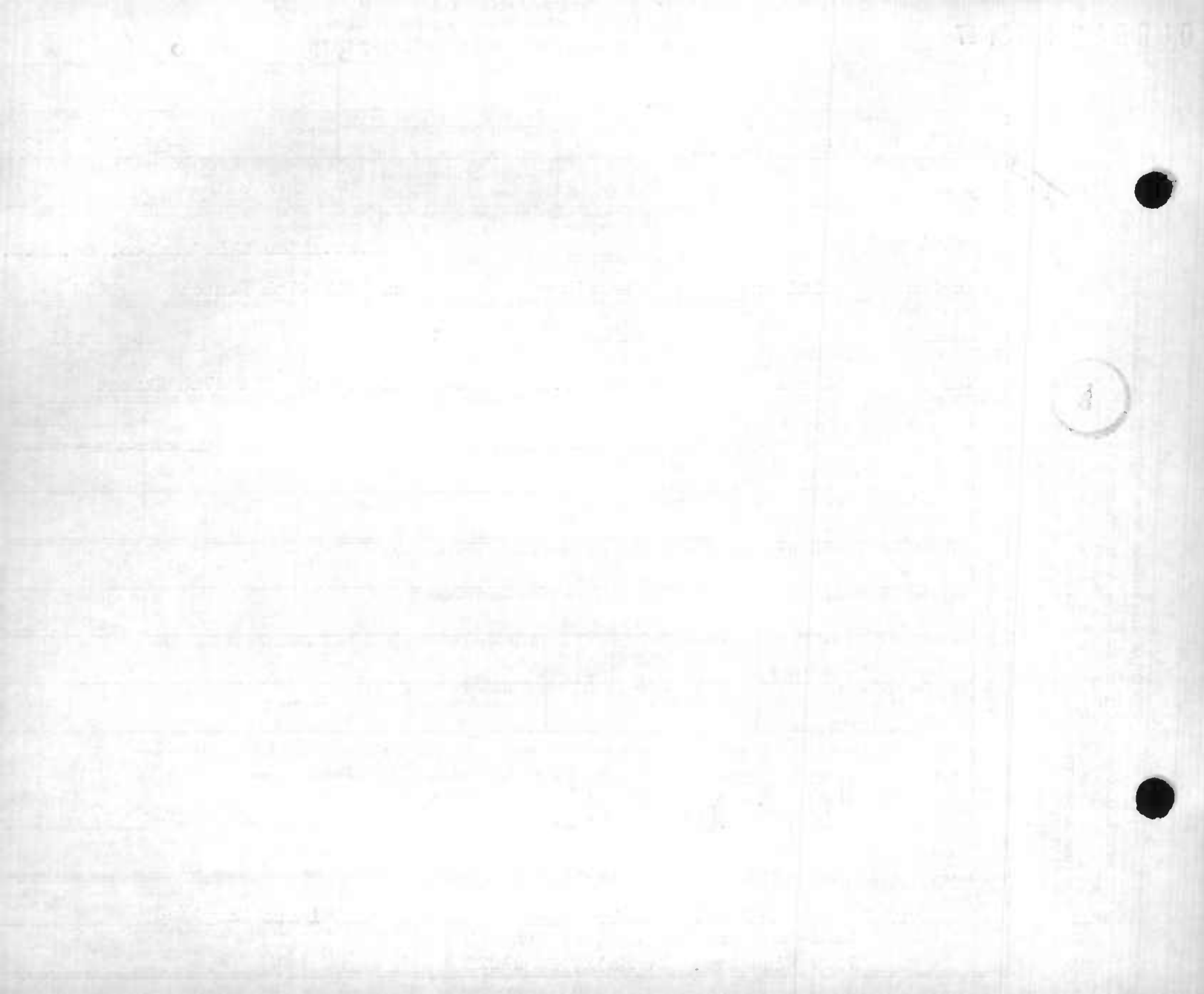
REG. NO. 06810

1. DECEASED NAME (TYPE OR PRINT) <b>MELVIN M. OCHAB</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3-25-87</b>			2b. HOUR M <b>10:30P</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7-4-32</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>54 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN <b>0 0</b>	2c. DATE PRONOUNCED DEAD <b>3-25-87</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>612 47th Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Battalion Chief Balto. Co. F.D.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. CITY <b>Baltimore</b>	13c. CITY OR TOWN <b>Dundalk</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>612 47th Street</b>		<b>21224</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Ochab</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Romenski</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea</b>		17. INFORMANT ADDRESS <b>Rose Marie Ochab 612 47th Street</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary carcinoma with metastases</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) <b>Asissant</b>			DATE <b>3-26-87</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-30-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk</b>			7922 Wise Ave. Dundalk, MD 21222			25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8706811  
REG. NO.

1 - FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		MARCH 11, 1987		2:07 PM	
3 SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE	WHITE	MAY 07, 1903	83	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
OHIO	U.S.A.		BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	ARMACOST NURSING HOME		RETIRED NURSE		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE
MD.		BALTO. CO.	COCKEYSVILLE		324 WICKERSHAM WAY. 21030
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
J. B. LONGFELLOW		JENNIE OGLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
NO		527-364489		FAMILY RECORDS	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ASCD		25 yrs
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/16 Dec. 1986 to 11/2 March 1987, that (I) (we) saw the deceased alive on 2 March 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
CHARLES O'DONNELL		7501 YORK ROAD, TOWSON, MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL		DULANEY VALLEY MEM.	COCKEYSVILLE, BALTO. CO. MD.
24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
EVANS CHAPEL OF CHIMES, TIMONIUM	MAR 13 1987		Lelia Deiden-Rudace

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CHIEF WINTER

1933-1934

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 31 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

8 7 REG. NO. 0 6 3 1 2

1. DECEASED NAME (TYPE OR PRINT)		LAST		MIDDLE		FIRST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Richard J.		OLSZEWSKI						March 6, 1987					12:00pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE		CAUC.		MONTH DAY YEAR 6 2 41		45 YRS.		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND		USA				Baltimore County						MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
BALTIMORE CO.		FRANKLIN SQUARE HOSPITAL		MACHINIST		DWIGGS CO								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
MARYLAND		BALTIMORE		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8595 PULASKI AVE 21224						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST JAMES OLSZEWSKI		FIRST MIDDLE LAST ROSALIE GORECKI												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
YES		217-386167		JAMES R. OLSZEWSKI		732 S. CURLEY ST.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
912		Cardiorespiratory arrest		Aspiration										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF										
				Metastatic adenocarcinoma, bowel obstruction										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (X) (this hospital) attended the deceased from February 27, 1987, to March 6, 1987, that (X) (we) lost saw the deceased alive on March 6, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.														
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED								
						3/6/87								
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS												
Angel Triana, M.D.		9000 Franklin Square Dr., Balto., 21237												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE								
BURIAL		MARCH 12, 1987		CROWNSVILLE VET.		A.A. COUNTY MD.								
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
RAYMOND L. KACZOROWSKI		MAR 12 1987												



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 06813

FOR 1 - STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST Mary	MIDDLE Frances	LAST Onnen	2a. DATE OF DEATH MONTH DAY YEAR 3 8 87		2b. HOUR 3:55 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 26 23		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 912 Army Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) admitting clerk		12b. KIND OF BUSINESS OR INDUSTRY hospital		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST C. Preston Saylor						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hallie May Engle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT John E. Onnen		ADDRESS 912 Army Rd. Baltimore, MD 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
9a. DATE OF OPERATION		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>W. B. Howard</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. B. Howard						22e. ADDRESS 201 E. Lincoln Pkwy. Baltimore MD 21218				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/9/87		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll MD				
24. FUNERAL DIRECTOR NAME D. D. Hartzler						ADDRESS Union Bridge, MD		25a. DATE REC'D. BY REGISTRAR MAR 11 1987		
						25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and incorporate Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

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WILEY & WILSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

87 REG. NO. 06814

1. DECEASED NAME (TYPE OR PRINT) Joseph W. Onorato			2a. DATE OF DEATH MONTH DAY YEAR 3/12/87			2b. HOUR MIN. 7:10 P.M.			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2/14/18		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILLWRIGHT-FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY GENERAL MTRS.	
13a. STATE md.			13b. COUNTY Balto.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 1830 Pennywood Rd. 21234			14. FATHER'S NAME FIRST MIDDLE LAST FRANK ONORATO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA ROSA TUMINELLO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II 316017706		17. INFORMANT ADDRESS ARMALFENE ONORATO (WIFE) SAME ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe coronary art. dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ischemic cardio myopathy.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Anoxic encephalopathy &amp; sudden death.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>3/9</u> , 19 <u>87</u> , to <u>3/12</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>3/12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph D'Antonio L.M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph D'Antonio L.M.D.					22e. ADDRESS 7901 2565 Drive Suite 110 Towson, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/16/87		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.		
24. FUNERAL HOME NAME ADDRESS SPALMONEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236					25a. DATE RECD. BY REGISTRAR MAR 17 1987				
25b. REGISTRAR'S SIGNATURE									

RECEIVED  
JAN 10 1944

TO: Mr. J. Edgar Hoover  
FROM: Mr. [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

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[Faint, mostly illegible text in the lower half of the page, possibly a continuation of the letter or a separate document.]

046685 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06815

1. DECEASED NAME (TYPE OR PRINT) <b>Gloria Rose ORTOLANO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 3, 1987</b>		2b. HOUR <b>11:05p</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 26 1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rossville 21237</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Franklin Sq. Hospital</b>				12a. USUAL OCCUPATION (IF NOT IN BUSINESS, INDUSTRY, OR SERVICE) <b>Machine Operator</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Middle River</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Richard</b> MIDDLE <b>Ladbrook</b> LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>Phelps</b> LAST		16. STREET ADDRESS / ZIP CODE <b>1410 Second Rd. 21220</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212 28 5014</b>		17. INFORMANT <b>Betty Willhoit, Sister Balto., Md. 21221</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary embolism, probable</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>80 minutes</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>3/3</b> 19 <b>87</b> to <b>3/3</b> 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>3/3</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Louis Olsen</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>3/4/87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louis Olsen, M.D.</b>	
22e. ADDRESS <b>1012 Old North Point Rd., 21224</b>				23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			
23b. DATE <b>3/6/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave</b>				25a. RECEIVED BY REGISTRAR <b>10 1987</b>			
25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, other traumatic event, or medical examination must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87		06810		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Dorothy J Otten				2a. DATE OF DEATH 3-14-87		2b. HOUR 1:19 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-15-22		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Towson MD.			
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1315 Mantle St. 21234	
14. FATHER'S NAME Charles Martin				15. MOTHER'S MAIDEN NAME Pearl Barger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-18-6733		17. INFORMANT ADDRESS Dorothy L. Eck 1319 Mantle St. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic CA of lungs DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic obstructive Pulm. Dis.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gracita K. Patericid				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gracita K. Patericid				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-16-87		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd. 21206				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAR 17 1987			

Michael's 20-7  
Wings

George Robertson Brown

✓ 3/1/12

W. W. W. W. W.  
W. W. W. W. W.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

046683 MAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87-06817  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Cora A. Owens					March 3, 1987				M
1. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White	Dec. 3, 1901			85	MONTHS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	USA				Baltimore County				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		
Middle River	1704 Wilson Point Rd.				Housewife		Home		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland		Baltimore		Middle River		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
William Sullens					Mary Collins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		217 48 3522		Harry Owens, Husband Same					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)				- 3 hours	
DUE TO, OR AS A CONSEQUENCE OF					
(b) recurrent antermyocardial infarction				- ?	
DUE TO, OR AS A CONSEQUENCE OF					
(c) Antermyocardial CVD				- 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 1972 to the present, that (I) (we) last saw the deceased alive on 2/19/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
MARVIN J. ROUBIN, MD					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
MARVIN J. ROUBIN, MD				805 Fuselage Ave	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3/6/87		Oak Lawn Cemetery	
23d. LOCATION		23e. CITY OR TOWN			
Baltimore Co., Md.		Baltimore Co., Md.			
24. FUNERAL DIRECTOR				25a. DATE RECEIVED BY REGISTRAR	
Brzezinski Funeral Home PA 1407 Old Eastern Ave				MAR 10 1987	
25b. REGISTRAR'S SIGNATURE					

March 2, 1987

John A. Cowan

Washington County

White

Dec. 2, 1981

USA

White River

120 Wilson Point Rd.

Home

120 Wilson Pt. Rd. 2120

Washington Middle West

120 Wilson Pt.

Wilson

Wilson

120 Wilson Pt. Rd. 2120

120 Wilson Pt.

120

1

Washington Co., Md.

One Law Center

2120

2120

Washington County, Md. 2120 One Law Center

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

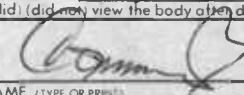
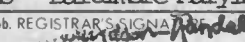
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified (circled).

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 -  
FOR  
STATE  
REGISTRAR

87 REG. NO. 06818

1. DECEASED NAME (TYPE OR PRINT) <b>Mr. Angelo Michael Pappas</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 20 1987</b>		2b. HOUR <b>2:10</b> M
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>February 4 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shoe Repairman</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Randallstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. IN BALTIMORE CITY <b>Miss Despina Angela Pappas</b> <b>3701 Downey Dale Drive Randallstown Maryland</b> <b>21133</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>DIABETES MELLITUS, CHRONIC OBSTRUCTIVE LUNG DISEASE, HYPERTENSION, STATUS POST COLECTOMY &amp; COLORECTIC CA.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-14</b> , 19 <b>87</b> , to <b>3-20</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3-20</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3-20-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRINKWOOD B. CONANAN, MD</b>		22e. ADDRESS <b>BEGH - RANDALLSTOWN Md. 21133</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-23-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Owings Mills Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc.</b> <b>8728 Liberty Road Randallstown, Maryland 21133</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1987</b>		
25b. REGISTRAR'S SIGNATURE 					

2/11/84





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 / REG. NO. 06819							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Preston F. Pardue				3 / 5 / 87		12 10 AM			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		White		12 15 13		73 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				BALTIMORE County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		St Joseph Hosp				Steel Worker		Steel Production	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md		Balto. City		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1411 Union Avenue 21211	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
George Lee Pardue		Maggie Keys							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		215 09 8951		Anna L. Pardue		same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF									
(b) CONGESTIVE HEART FAILURE									
DUE TO, OR AS A CONSEQUENCE OF									
(c) SEVERE AORTIC VALVE INSUFFICIENCY									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
CALCIFIC STENOSIS OF BICUSPID AORTIC VALVE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 2-5, 19 87, to 3-5, 19 87, that (we) last saw the deceased alive on 3-5, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (we) (did) (did not) view the body after death. <input checked="" type="checkbox"/>									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
REYNALDO ORJUELA-GOMEZ, M.D.						3-5-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
REYNALDO ORJUELA-GOMEZ, M.D.		7620-YORK RD TOWSON MD 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		03/09/87		Woodlawn cemetery		Woodlawn, Balto. Co. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Burgee-Henss Funeral Home 3631 Falls Rd 21211				MAR 09 1987		Julia Sanders-Randall			

BP



Handwritten text in Devanagari script, mostly illegible due to fading. Some visible words include "प्रमाण" (Proof) and "संख्या" (Number).

Handwritten text in Devanagari script, mostly illegible due to fading. Some visible words include "प्रमाण" (Proof) and "संख्या" (Number).

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <u>JAN L. PARKER</u>					2a. DATE OF DEATH MONTH <u>3</u> DAY <u>13</u> YEAR <u>87</u>		2b. HOUR <u>10<sup>00</sup></u> M		
1. SEX <u>Female</u>		4. RACE <u>Cauc.</u>		5. DATE OF BIRTH MONTH <u>7</u> DAY <u>20</u> YEAR <u>51</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>35</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.			
10. CITY OR TOWN OF DEATH <u>Towson</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Stella Maris Hospice</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Attorney</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
13a. STATE <u>MD.</u>		13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Westminster</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>1135 Deer Park Rd. 21157</u>	
14. FATHER'S NAME FIRST <u>Jack</u> MIDDLE <u>C.</u> LAST <u>Leutritz</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Elizabeth</u> MIDDLE <u></u> LAST <u>Moore</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>na</u>		17. INFORMANT <u>David Parker</u>		ADDRESS <u>13e</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic breast carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 10, 1987</u> to <u>March 13, 1987</u> , that (I) (we) last saw the deceased alive on <u>March 13, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Carla S. Alexander</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Carla S. Alexander, M.D.</u>				22e. ADDRESS <u>Stella Maris Dulaney Valley Rd. - Towson, MD 21204</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/17/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kriders</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Westminster Carroll MD</u>			
24. FUNERAL DIRECTOR NAME <u>Robert K. Pritts, Sr.,</u> ADDRESS <u>Westminster, MD</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 17 1987</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>					

100

EDUCATIONAL

100

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "B", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clement J. Patrick						2a. DATE OF DEATH MONTH DAY YEAR 3/4/87		2b. HOUR 6:20 P M	
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1/16/15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printing Sales		12b. KIND OF BUSINESS OR INDUSTRY Bromwell Press	
13a. STATE md.		13b. CITY OR TOWN Balto.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 4500 Marble Hall Rd. 21239			
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Patrick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Dunleavy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 205-07-4053		17. INFORMANT ADDRESS Margaret B. Patrick Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injured arteries graft + GI hemorrhage. DUE TO, OR AS A CONSEQUENCE OF (b) Perforated duodenal ulcer. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Pneumonia									
19a. DATE OF OPERATION 2/1/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intra-abdominal hemorrhage				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/26 19 87, to 3/4 19 87, that (I) (we) lost saw the deceased alive on 3/4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John H. Eppler				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/4/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Eppler				22e. ADDRESS 205 Julee Pierce Dr. Towson.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/7/87		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md.				24b. ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR MAR 05 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

14820

WEDNESDAY  
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WEDNESDAY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, in accordance with the instructions on page 3, the certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, another traumatic event, the medical examiner must be notified before.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

06822

FOR  
STATE  
REGISTRATION 07

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
VIRGINIA L.		PATTERSON		March 6, 1987		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Female	White	January 24, 1948		39 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.	USA			Balto. County MD.			
11. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Parkville	1745 Wycliffe Road		Homemaker				
13a. STATE				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE	
Md.						1745 Wycliffe Rd. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
F. Vernon Czarnowsky Jr.		Jimmie Virginia Winters					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		220-52-6450		Mr. Brian K. Patterson Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Ca of Cervix</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James H. Dorsey M.D.</u>				DEGREE		22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES H. DORSEY MD</u> Francis Grumbine M.D.				22c. ADDRESS <u>G.B.M.C. Professional Building</u>		3/6/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Mar. 9, 1987		Parkwood		Baltimore Maryland	
24. FUNERAL DIRECTOR NAME <u>Leonard J. Ruck, Inc.</u> ADDRESS <u>5305 Harford Road 21214</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 09 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

Handwritten vertical text, possibly a date or reference number, including the characters "1945" and "100".





048156 MAR 26 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other than natural event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Wilbur Pearce</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 18 1987</b>			2b. HOUR M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 15 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Balto. Med. Ctr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Agricultural</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Cockeysville</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Stabler Pearce</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna - Scott</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17. INFORMANT ADDRESS <b>Mrs. Virginia B. Pearce same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respirator failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>-</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 87</b> , to <b>3/18/ 87</b> , that (I) (we) last saw the deceased alive on <b>Jan 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>G. Bedon MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/18/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE BEDON MD</b>				22e. ADDRESS <b>660 Knapworth Drive - Balto Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>March 21, '87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bosley Church Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>				10 W. Padonia Road		25b. REGISTRAR'S SIGNATURE <b>Si. Fisher</b>			

50% COTTON FIBRE



100% COTTON FIBRE



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06824

1- FOR STATE REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST  
ANNE S. PECKHAM.

2a. DATE OF DEATH MONTH DAY YEAR  
3 24 87

2b. HOUR  
3:55 PM

3. SEX FEMALE

4. RACE WHITE

5. DATE OF BIRTH MONTH DAY YEAR  
JUNE 23, 1934

6. AGE (IN YEARS LAST BIRTHDAY)  
52 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
N.Y.

7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH  
BALTIMORE COUNTY MD.

10. CITY OR TOWN OF DEATH  
TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
STELLA MARIS HOSPICE

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
PSYCHOLOGIST

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE  
FLA.

13b. CITY OR TOWN  
BAYTON BEACH

13c. STREET ADDRESS / ZIP CODE  
719 S.W. LAKE CT. 33435

14. FATHER'S NAME FIRST MIDDLE LAST  
HAROLD A. STORMS

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
RUTH WILLIS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
NO

16b. SOCIAL SECURITY NO.  
103-288269

17. INFORMANT ADDRESS  
FAMILY RECORDS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SUPERIOR VENA CAVA SYNDROME AND  
LUNG CANCER (ADENOCARCINOMA)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF  
(b)  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-19-87, to 3-24-87, that (I) ☒ saw the deceased alive on 3-24-87, and that in (my) ☒ opinion death occurred on the date and hour and from the causes stated above, (I) ☒ did (did not) view the body after death.

22b. SIGNATURE DEGREE  
Carla S. Alexander MD

22c. DATE SIGNED  
3-24-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
Carla Alexander, M.D.

22e. ADDRESS  
Stella Maris Hospice  
Dulaney Valley Rd.-Towson, MD 21204

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
BURIED

23b. DATE  
3-25-1987

23c. NAME OF CEMETERY OR CREMATORY  
GREEN MOUNT CEM.

23d. LOCATION CITY OR TOWN COUNTY STATE  
BALTIMORE MD.

24. FUNERAL DIRECTOR  
EVANS CHAPEL OF CHIMES YORK RD

25a. DATE REC'D. BY REGISTRAR  
MAR 27 1987

25b. REGISTRAR'S SIGNATURE  
Julia Davidson-Randall



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this form to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>ANNA E. PENN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 14, 1987</b>		2b. HOUR <b>8:58 A.M.</b>		
3. SEX <b>FW</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 7 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Oper. Rm. Techn.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Johns Hopkins</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Hospital</b>		13d. STREET ADDRESS / ZIP CODE <b>339 Elinor Avenue 21236</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank P. Ray</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Angel</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-14-6693</b>		17. INFORMANT ADDRESS <b>Ruth P. Wilson 339 Elinor Ave. Balto., Md. 21236</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 12 1987</b> to <b>Mar 14 1987</b> , that (I) (we) lost saw the deceased alive on <b>Mar 13 1987</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert E. Storer</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>Mar 14 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert E. Storer</b>					22e. ADDRESS <b>Suite 506 120 Sister Pierre Dr 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-16-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Lassman Funeral Home</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 17 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Friedman</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked for item 18, show any injury, or other trauma, etc. event, the medical examiner must be contacted at once.)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06826

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Catherine R. Peters</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 31 87</i>		2b. HOUR <i>2:35 AM</i>					
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 11 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALTIMORE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. COUNTY</i> MD.				
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Stella Maris Hospice</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Md.</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baldwin</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>13701 Alliston Dr. Baldwin, Md. 21013</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert A. GAYLEARD</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Paulena R. Schmidt</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>218 18 9141 A</i>		17. INFORMANT ADDRESS <i>Mrs. Paulena R. Dougherty Baldwin, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca pancreas with metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>3/31/87</i> 19 <i>87</i> , to <i>3/31</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>3-31</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Eddie Nakhuda, M.D.</i>				22c. DATE SIGNED <i>3/31/87</i>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stella Maris</i>		
22e. ADDRESS <i>Dulaney Valley Rd. - Towson, MD 21204</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/2/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Louis Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Clarksville, Md.</i>				
24. FUNERAL DIRECTOR NAME <i>MITCHELL-WIEDEFELD HOME, INC.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR - 1 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

BP



*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "COTTON" and "SHEEP" are visible.]*



*[Faint text at the bottom of the page, including a date stamp that appears to read "APR 1 1901".]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other cause of death, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		87 REG. NO. 06827									
1a. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
HOWARD N. PHILLIPS								03 118 87		8:25PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		December 11, 1918		68 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Georgia		USA				Baltimore, County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph Hospital				Crane Operator			Beth. Steel		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore		Towson				17 Treeway Court Apt 3A 21204			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Lawrence Phillips				Lillie Echols							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				WW II		Margaret Phillips 17 Treeway Court Apt 3A					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Oat Cell CA c CNS Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>3/18/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/18/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Shirley Thompson MD</u>				DEGREE				22c. DATE SIGNED <u>3/18/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3-23-87		Gardens of Faith		Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222						MAR 20 1987		<u>Lia Davidson</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove certificates pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

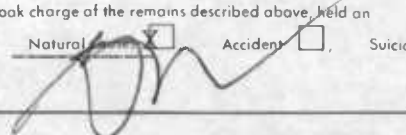

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR XC 4656315					8 REG. NO. 06828				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD OLIVER PHILLIPS					2a. DATE OF DEATH MONTH DAY YEAR MARCH 25, 1987			2b. HOUR 6:30 A	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 18 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A.M.C., FORT HOWARD, MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired- Army		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 201 MIDDLEWAY ROAD APT 1A 21220	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM PHILLIPS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH DUNNOCK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 217 10 8979		17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>EXTREME MALNUTRITION</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 9</u> , 19 <u>87</u> , to <u>MARCH 25</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>C.V.J. Verghese</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3-25-87	
22d. PHYSICIAN'S NAME C.V.J. VERGHESE, M.D.				22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MD 21052					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/28/87		23c. NAME OF CEMETERY OR CREMATORY HollyHillCemetery		23d. LOCATION CITY OR TOWN COUNTY STATE MiddleRiverBalto. Md.			
24. FUNERAL DIRECTOR NAME ConnellyFuneralHome				ADDRESS 300MadAve. 21221		25a. DATE REC'D. BY REGISTRAR MAR 31 1987			
						25b. REGISTRAR'S SIGNATURE <i>Julia E. ...</i>			

*[Faint, illegible markings]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC'D NO 6 8 2 9	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Piperno							2a. DATE KNOWN OF DEATH ESTIMATED 3/15/1987		2b. HOUR 10:16		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-19-1938		6. AGE (IN YEARS) 48 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 3/15/1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD		
11. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baggage Handler		12b. KIND OF BUSINESS OR INDUSTRY TWA		
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9170 Ft. Smallwood Rd. 21122			
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Piperno						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Swinkowski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 206-30-4744		17. INFORMANT Kingston, PA ADDRESS 18704 Mr. Leonard P. Piperno 50 S. Wells Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 3/16/87		
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.						ADDRESS 111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-20-87		23c. NAME OF CEMETERY OR CREMATORY Memorial Shrine Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Carrington-Wyoming Luzerne PA	
24. FUNERAL DIRECTOR NAME Loring Byers, Funeral Directors, Inc						25a. DATE REC'D. BY REGISTRAR MAR 19 1987		25b. REGISTRAR'S SIGNATURE 			
8728 Liberty Rd. Randallstown, MD 21133											

Q3613 MDT000 2902

DAVID WATKINS





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic evidence, medical examiner must be called to certify.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06830

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ALBERT		JOSEPH		PIZZA		3-21-87 1:24p M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.	
MALE		WHITE		DECEMBER 16, 1910		76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD		VA MEDICAL CENTER, FT. HOWARD, MD		CHAUFFEUR			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE	
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		320 S. High St. 21202	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
ANTHONY J PIZZA		ROSE MARANO					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		220 09 0902		CLIN. RECDS. VAMC, FORT HOWARD, MD. 21052			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>REFRACTORY CONGESTIVE HEART FAILURE WITH PULMONARY EDEMA</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>CARDIOGENIC SHOCK, SEPTIC SHOCK</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>12/31</u> , 19 <u>86</u> , to <u>3/21</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>3/21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE				22c. DATE SIGNED	
<i>Alfonso Ruiz</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				3-21-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
A. RUIZ, M.D.		VA MEDICAL CENTER, FT. HOWARD, MD. 21052					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		3/24/87		GARDENS OF FAITH		BALTO MD.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Frank R. Ruiz</i>		322 S. High St. 21202		MAR 26 1987		<i>John L. Smith</i>	

EX-100

RECEIVED



3/24/71 CARDINAL  
WAS 2:00 PM

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

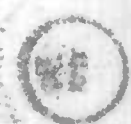
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove this page with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: Item 21 is marked or item 18 shows only injury, or other traumatic event. If the death certificate must be retained at the hospital, the funeral director must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8706831		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		2-7-05		82		YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD		USA				B. COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		RIVERVIEW NURSING CENTRE		Tike Setter		Tike Business			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MD.				Baltimore City		YES		320 S. HIGH ST 21202	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
ANTHONY PIZZA		ROSE		No		218-10-2586		ANTHONY SCHIANG 3800 ALEMEDA 21218	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		912		DUE TO, OR AS A CONSEQUENCE OF (b)		Arteriosclerotic Coronary Vascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		Chronic Obstructive Pulmonary Disease.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Michael Schianga MD				3-16-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3/19/87		GARDENS OF FAITH		Baltimore MD.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Michael Schianga		320 S. High St		MAR 18 1987		Julia Schianga			

3/18/81  
MAY 18 1981  
JAN 18 1981



20% CO-10-2

Handwritten notes and stamps, including a large circular stamp on the right side of the page.

048235 MAR 26 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

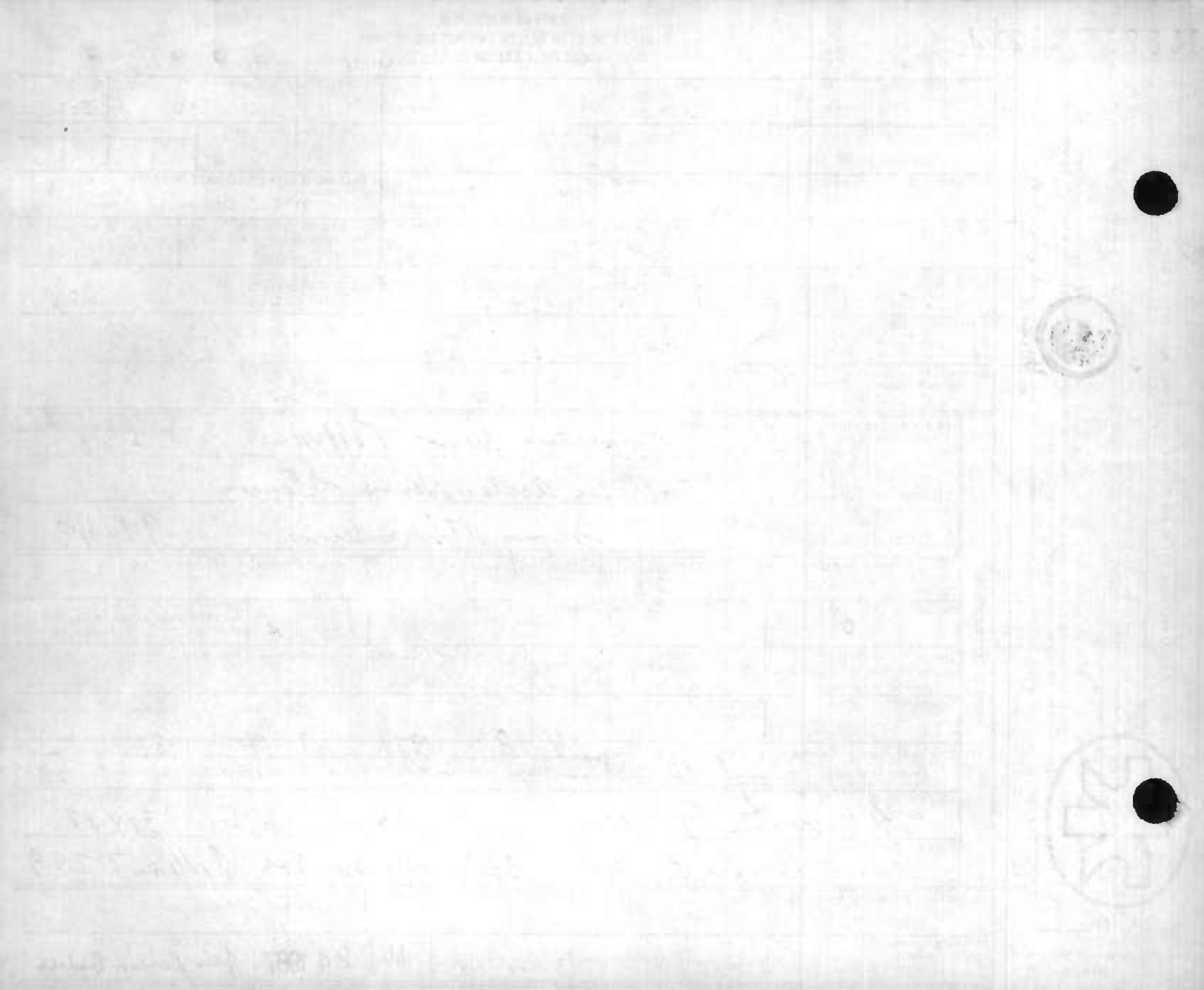
87 06832  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWIN T. PLANT			2a. DATE OF DEATH MONTH DAY YEAR 3 11 87		2b. HOUR A M 5:18 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 27 06	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto City CO. MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4109 Villa Nova Road 21207		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent		12b. KIND OF BUSINESS OR INDUSTRY Real Estate
13a. STATE Md.		13b. COUNTY Balto	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leo Plant		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Hewitt		13e. STREET ADDRESS 4109 Villa Nova Road 21207	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 074-07-6007		17. INFORMANT ADDRESS Mrs. Marjorie Plant - Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Calcific Aortic Nerve of Aorta</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>9-10 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 0		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-14-87</u> to <u>3-11-87</u> , that (I) (we) lost <u>4-18-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Kyle G. Swisher Jr MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-14-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kyle G. Swisher Jr MD		22e. ADDRESS 3455 Wilkens Ave - Baltimore 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 3-11-87		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR MAR 24 1987			
24. FUNERAL DIRECTOR NAME State Anatomy Board		ADDRESS Balto., Md.		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M  
BP  
DHMH - 17  
(VR A15 ME (1))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. 6. 3 3 3			
1- FOR STATE REGISTRAR							2a. DATE KNOWN OF DEATH		2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES A POWER							MONTH DAY YEAR 19		M				
3. SEX F		4. RACE W		5. DATE OF BIRTH (LAST BIRTHDAY) MONTH DAY YEAR 5 10 1925		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 61 YRS.		7c. DATE PRONOUNCED DEAD MAR 3 1987		2d. HOUR 6:55 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Carney				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9629 Ninth Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Domestic			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Carney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9629 Ninth Avenue 21234			
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Eburg							15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanch J. Trush						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 215-20-9676		17. INFORMANT ADDRESS Michael Power P.O. Box 281 Susquehanna Camp Churchville, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO DUE TO, OR AS A CONSEQUENCE OF VASCULAR DISEASE (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE PAUL F GUERIN				TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER				DATE SIGNED 3/3/87					
EXAMINER'S NAME (TYPE OR PRINT) PAUL F GUERIN				ADDRESS 1201 KRUGGER AVE BALTIMORE MD 21237									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 3-3-87		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation Service				23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Carroll, Maryland			
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service						ADDRESS Upperco, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 04 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			



10-11-10

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9182 APR -3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH - 17  
(VR AIS ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6 8 3 4

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR				
VERNON GRAY POWERS						3-25-87			19			M				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR			
MALE	WHITE	NOV-30-1915	71				3-25-87			19			3:50P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
NORTH CAROLINA			U.S.A.						Baltimore County MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cockeysville			10825 Hollow Rd.			GRINDER			BLACK & OIL			21030				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE			13b. CITY OR TOWN			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
MARYLAND			BALTIMORE			COCKEYSVILLE			YES			10825 HOLLOW ROAD				
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
REV. WALTER G. POWERS						MARTHA L. POWERS										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO						219 016546			FAMILY RECORDS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>disease</u> (c) <u></u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																
ACTUAL SIGNATURE <u>Margaret McCall</u>						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 3-26-87				
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial			3-28-1987			Poplar Grove			Phoenix Baltimore Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
EVANS CHAPLOFCHimes York Road						2325			MAR 27 1987			Julia Davidson-Rodale				

Handwritten notes and calculations, including a large 'X' and a circular stamp.



46404

MAR-9

Item # 5, Film G 625 3/13/87 ra

1 - STATE  
FOR  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 REG. NO. 06835  
2a. DATE OF DEATH MONTH DAY YEAR 3 3 87  
2b. HOUR 7:25 AM

1. DECEASED NAME (TYPE OR PRINT) Georges W. Pressier			2a. DATE OF DEATH MONTH DAY YEAR 3 3 87			2b. HOUR 7:25 AM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 29 87	6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.			IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD.			
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 1207 Brookmeadow Dr. 21204			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR Advertising & Publishing		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. CITY OR TOWN Baltimore			13c. STREET ADDRESS, ZIP CODE 1207 Brookmeadow Dr. 21204			
14. FATHER'S NAME FIRST MIDDLE LAST John R. Presser			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Weishiet						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 141-28-3361			17. INFORMANT ADDRESS Mrs. Ruth Presser Same as 13c			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Immediate

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

Acrony ant. disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Congestive cardiac failure

yes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 27, 19 81, to March 3, 19 87, that (I) (we) lost saw the deceased alive on JAN 2, 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE Edwin J. Berstock M.D.		22c. DATE SIGNED 3/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin J. Berstock M.D.		22e. ADDRESS 302 East 33rd Street	

23a. BURIAL, CREMATION, REMOVAL Cremation	23b. DATE 3/4/87	23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery	23d. LOCATION Baltimore, Md.
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR MAR 05 1987	
		25b. REGISTRAR'S SIGNATURE John Edgar Ruck	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please attach this to the other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other event, the medical attention and the signing of death certificate.



046843 MAR 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

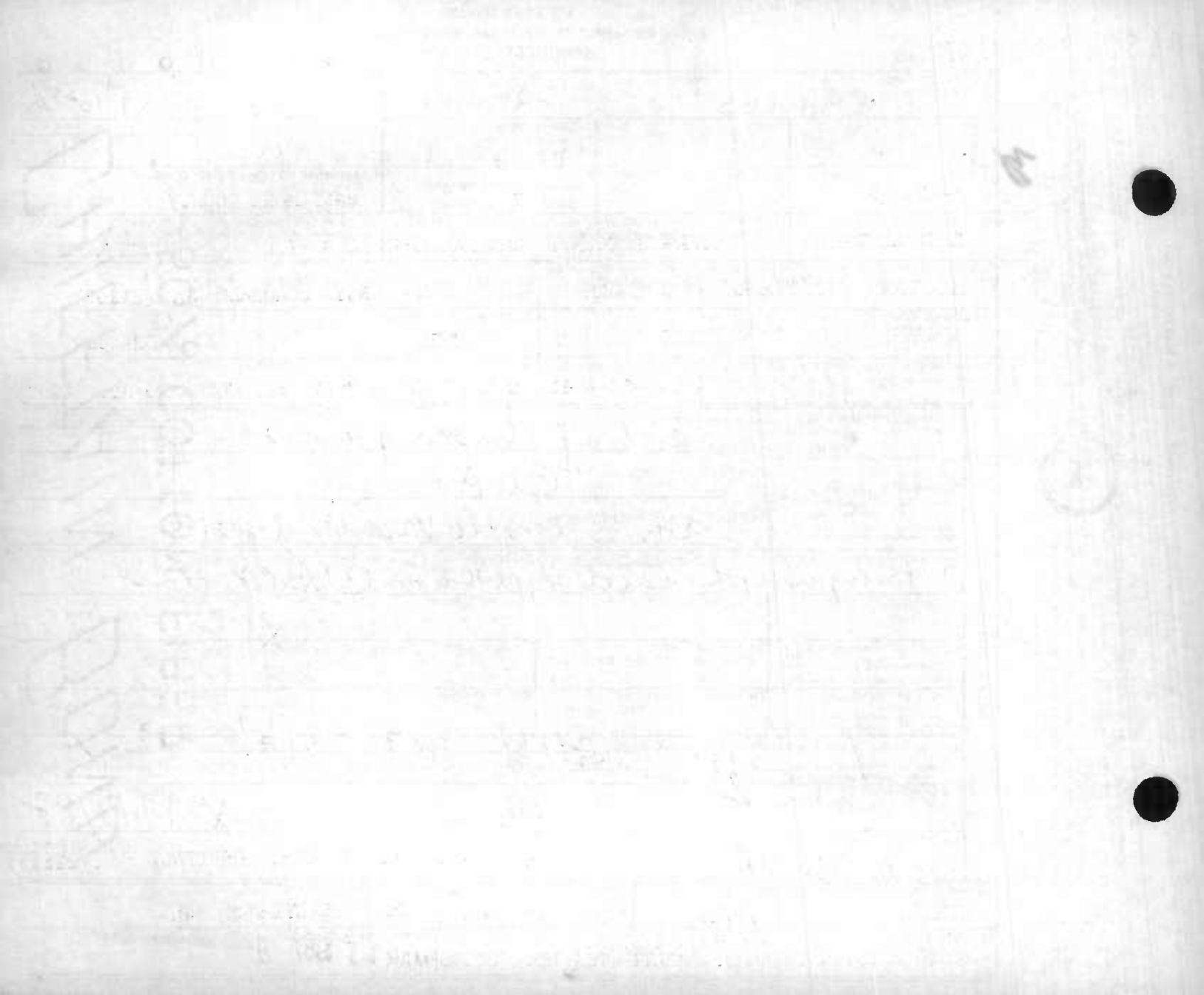
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return it to the Registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked as true, it shows any injury, or other traumatic event, the medical examiner must be notified of immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES PRISMAN					2. DATE OF DEATH MONTH DAY YEAR 3 7 87			2b. HOUR 10:25 AM	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 23 98		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN MARYLAND BALTIMORE BALTIMORE					13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 3616 CORONADO RD. (21207)		
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN YAFFE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHEL UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-50-4041		17. INFORMANT ADDRESS MRS. EVELYN ROFSKY 3616 CORONADO RD. (21207)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic vascular disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Tachyarrhythmias</u> (b) <u>Hypertension</u> (c) <u>Aspiration</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I (this hospital) attended the deceased from <u>2/13/87</u> to <u>3/7/87</u> , that I (we) last saw the deceased alive on <u>2/7/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>3/7/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Smolk</u>				22e. ADDRESS <u>BALTIMORE COUNTY GEN. HOSPITAL, RANDALLSTOWN, Md. (21133)</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/8/87		23c. NAME OF CEMETERY OR CREMATORY SWINICHER WOLINER CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 11 1987 <u>[Signature]</u>					

BP \_\_\_\_\_





047647

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper for pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06837

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ELIZABETH

D

PROCTOR

2a. DATE OF DEATH

MONTH 3 DAY 4 YEAR 87

2b. HOUR

4:25 PM

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

MONTH 10 DAY 31 YEAR 1903

6. AGE (IN YEARS LAST BIRTHDAY)

83

YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Deacon Hospital - Medical Center

12a. USUAL OCCUPATION

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

None

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

PG

13c. CITY OR TOWN

Glen Arden

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

7904 Johnson Avenue

20706

14. FATHER'S NAME

William

MIDDLE

G.

LAST

Harley

15. MOTHER'S MAIDEN NAME

Marie

MIDDLE

E.

LAST

Proctor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

213-54-5936

17. INFORMANT

James E. Proctor

ADDRESS

7904 Johnson Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory failure - pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b)

Cerebral anoxia - encephalopathy

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 52 Jan 1987 to 4 March 1987, that (I) (we) last

saw the deceased alive on 4 March 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

J.W. Reed M.D.

DEGREE

ATTENDING

MEDICAL

STAFF

PHYSICIAN ☐DIRECTOR ☒PHYSICIAN ☐

22c. DATE SIGNED

3/5/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

J.W. REED M.D.

22e. ADDRESS

611 S. CHAS ST BALD. MD. 21208

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

03-09-87

23c. NAME OF CEMETERY OR CREMATORY

Lincoln Mem. Cemetery

23d. LOCATION

CITY OR TOWN

Sutland

COUNTY

PG

STATE

Maryland

24. FUNERAL DIRECTOR

NAME

Robert G. Mason 1661 Good Hope Rd., S.E.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

MAR 18 1987

25b. REGISTRAR'S SIGNATURE

J. W. Reed

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

02237

1947

SECTION



047902 MAR 23 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REC NO. 06838

1. DECEASED NAME (TYPE OR PRINT) <b>HELENA D. Quinn</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 11 1987</b>			2b. HOUR <b>2:18 M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 9 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Ruxton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE - Ruxton</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RET. MAJOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>282062 Moor Road 21093</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT J. Quinn</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE M. SULLIVAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>FAMILY RECORDS</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY COLLAPSE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>HYPERTENSION - DIABETES</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1984</b> to <b>MAR</b> 19 <b>87</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>MAR 9</b> 19 <b>87</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <b>R. W. Lisle</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>MARCH 13, 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ROBERT W. LISLE</b>			22e. ADDRESS <b>57 WEST TIMONIUM ROAD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3-14-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD Lsm.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PARKVILLE BALTO. MD.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>EVANS CHAPEL OF CHIMES YORK ROAD 2325</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1987</b>			25b. REGISTRAR'S SIGNATURE <b>John Gordon Radner</b>			

MEDICAL CERTIFICATION

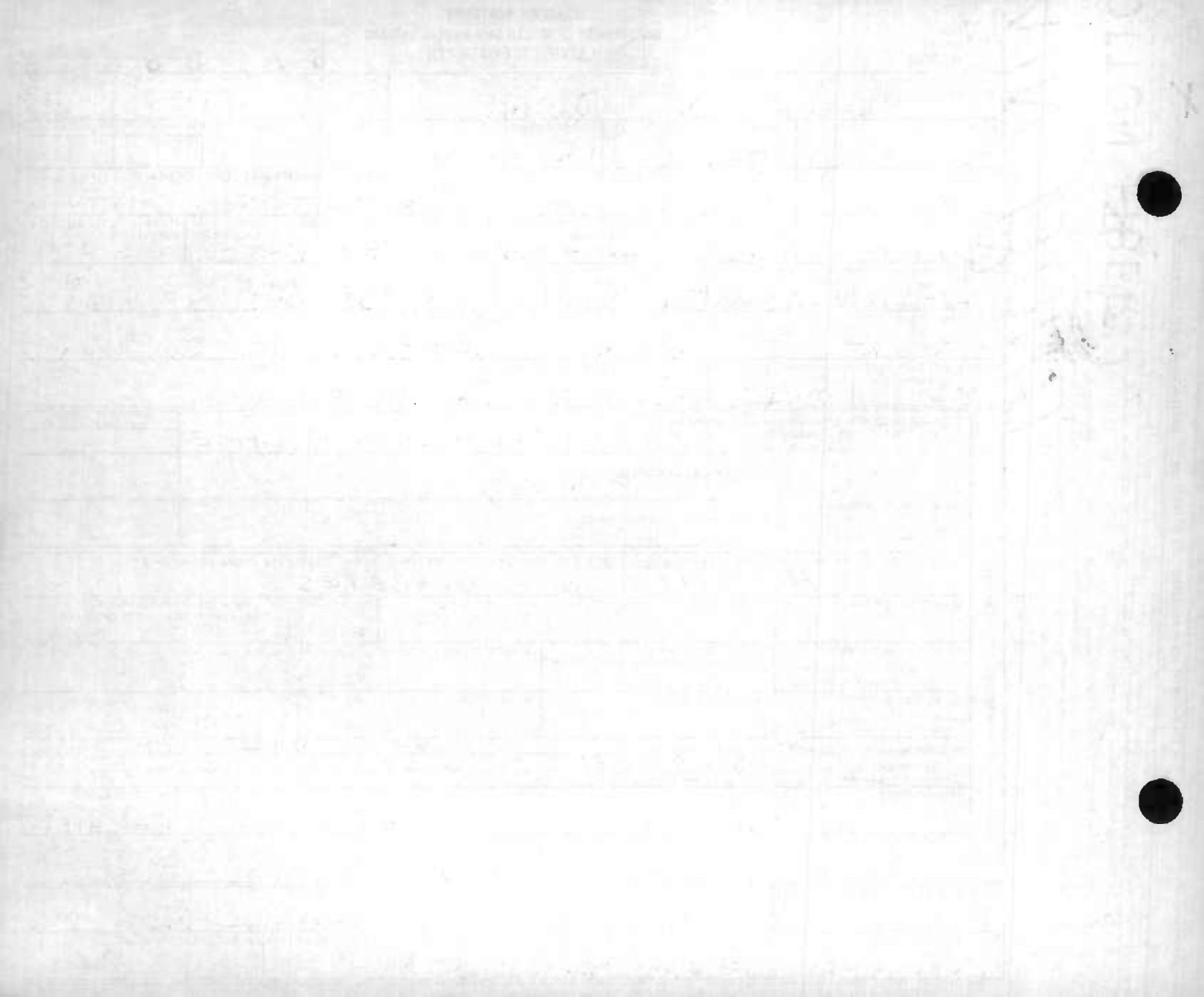
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



046716 MAR 11

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06839

1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH MORRIS RANCK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>March 5 1987</b>		2b. HOUR <b>19:05</b> M	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 19 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Dundalk</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1950 Wareham Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Dundalk</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Morris</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Speed</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-74-1391</b>		17. INFORMANT ADDRESS <b>Eleanor Schreiber same as 13e</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did, did not, view the body after death.					
22b. SIGNATURE <b>J.M. Niehoff</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/6/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.M. Niehoff, M.D.</b>		22e. ADDRESS <b>6800 Morningside Road Balto., Md. 21222</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-9-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillside Cemetery</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Ave Balto Md 21222</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Philadelphia Pennsylvania</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 09 1987</b>	
		25b. REGISTRAR'S SIGNATURE <b>John E. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

20% CO<sub>2</sub> IN FEB

CHIEFMAN BOW



048436 MAR 30 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06840  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thoma s RANDOLPH			2a. DATE OF DEATH MONTH DAY YEAR March 24, 1987		2b. HOUR 6:15 a.m.
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 3 10 1935		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rosedale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bethlehem Steel	12b. KIND OF BUSINESS OR INDUSTRY STEEL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Turners Station	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 114 Oak St. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Randolph			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Gillian		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-32-5006		17. INFORMANT ADDRESS Mrs. Thelma Randolph 114 Oak St. 21222	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Probable Acute Bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from January 31, 19 87, to March 24, 19 87, that (we) lost saw the deceased alive on March 24, 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death,			
22b. SIGNATURE Kirk Steptoe, M.D.	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kirk Steptoe, M.D.	22e. ADDRESS 9000 Franklin Square Drive, 21237		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-28-87	23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem PK.	23d. LOCATION City or Town County State Laurel Md.
24. FUNERAL DIRECTOR NAME James A. Morton + Sons		ADDRESS 1701 Laurens	25a. DATE REC'D. BY REGISTRAR MAR 27 1987
		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall	

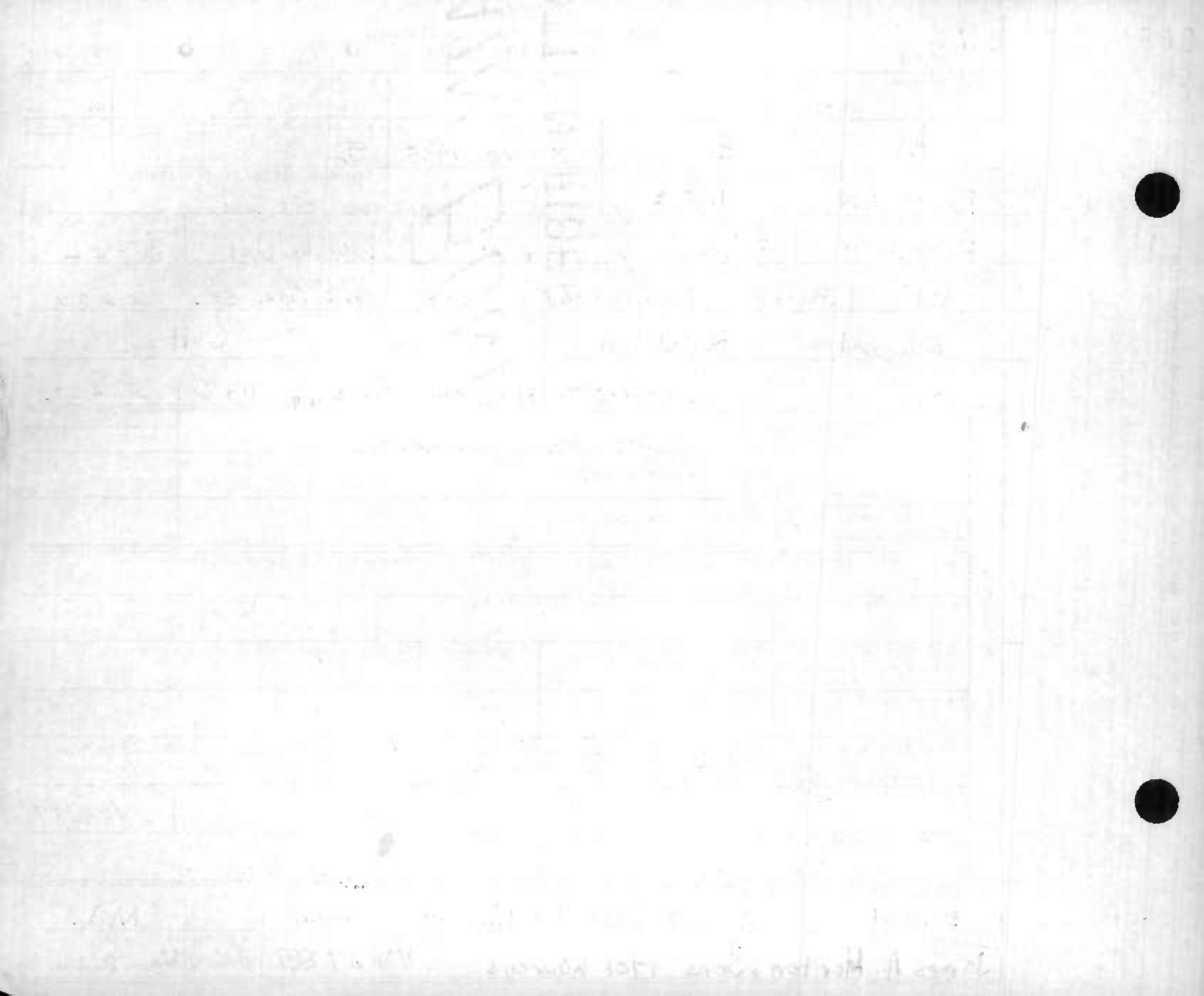
BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 06841

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FANNIE RATNER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3 20 87</b>		2b. HOUR <b>02.25<sup>M</sup></b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 16, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO. CO. GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. STREET ADDRESS / ZIP CODE <b>4212 NADINE DR. #21215</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN BARANOFF</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ETTA RAISA UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>060-34-3056A</b>	
		17. INFORMANT <b>MRS. ROSALIND FRIEDMAN</b>		17. ADDRESS <b>4212 NADINE DR. BALTO., MD 21215</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>87</u> , to <u>3/20</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Young J. Ro</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/20/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Young J. Ro MD</u>		22e. ADDRESS <u>B. C. G. H.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL/BURIAL</b>		23b. DATE <b>MAR. 22, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>UNITED HEBREW CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>STATEN ISLAND NEW YORK</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1987</b>		25b. REGISTRAR'S SIGNATURE <u>Julia Levinson</u>	
6010 REISTERSTOWN RD. BALTO., MD 21215							

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SECTION CIBER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 06842

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rose E. RATTMAN		2a. DATE OF DEATH MONTH DAY YEAR 3 2 87		2b. HOUR 2:00 PM
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR 2 13 96		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Balto.		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles Gallion		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-74-7230		17. INFORMANT ADDRESS 21236 William A. Rattman Jr. 8815 Dearborn Dr.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

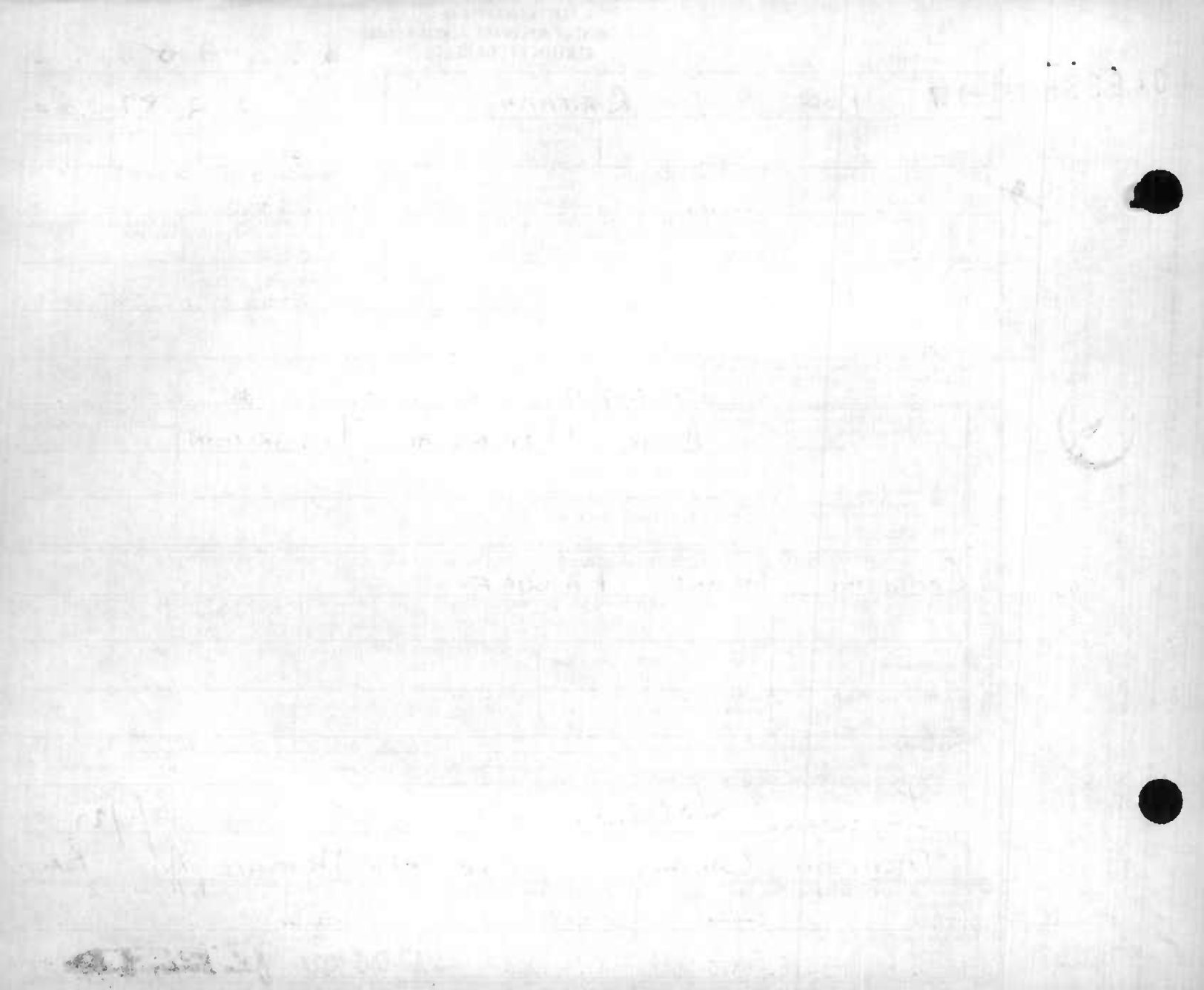
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. Congestive Heart Failure			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22c. DATE SIGNED 3/3/87
22b. SIGNATURE Tasneem Lakhani		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TASNEEM LAKHANI	22e. ADDRESS 7220 PARK HEIGHTS AVE BALTO	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-4-87	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md.
24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd. 21206		25a. DATE REC'D. BY REGISTRAR MAR 06 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06843

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (Type or Print)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
JOSEPH		G.		REDD				DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		3-31-87 19	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
MALE	Negro	10-29-46		40 YRS.		MONTHS		DAYS		3-31-87 19	
7a. BIRTHPLACE (State or Foreign Country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
BALTO.		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (If not in such facility, give street address)				12a. USUAL OCCUPATION (Type of work for most of working life)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTO.		6141 Marquette Rd. Apt. K									
13a. USUAL RESIDENCE (If in nursing home, or other institution, give residence before admission)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
BALTO.		BALTO.		BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		#312 6141 Marquette Rd			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Joseph		Christine		YES		212-42-6136		PATRICIA BETTS 1129 N. Caroline ST #312/3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Gunshot wound of chest											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in item 18 part 1 or part 2)			
3-15AM 3-31-87				15AM 3-31-87				self/inflicted			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, street, factory, farm, etc.)				21f. LOCATION			
home				home				6141 Marquette Rd. Apt. K Balto, Co., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Margarita A. Korell, M.D.				M.D. Assistant				3-31-87			
EXAMINER'S NAME (Type or Print)				ADDRESS							
Margarita A. Korell, M.D.				111 Penn Street							
22b. BURIAL (Type or Print)		22c. DATE		22d. NAME OF CEMETERY OR CREMATORY				22e. LOCATION			
REMOVAL, REMOVAL		4/3/87		Hawthorne Cerm.				BALTO.			
24. FUNERAL DIRECTOR		NAME		ADDRESS		DATE REGD. BY REGISTRAR		NATURE			
BETTS Funeral Home		1129 N. Caroline St.				APR - 2 1987		John Betts			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. The medical examiner's removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1- FOR STATE REGISTRAR		8		7		0		6		8		4		1	
1. DECEASED NAME (TYPE OR PRINT) <b>Gregory Reillo</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 05 1987</b>				2b. HOUR <b>2:59 AM</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 15 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Portugal</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.									
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Forest Haven Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Ribor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shipping/Drydock</b>							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b>				13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>314 S. Maderia St. 21231</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Geronimo Reillo</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Aurora Fernandez</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-07-3556</b>		17. INFORMANT ADDRESS <b>Aurora Reillo 9515 Perrybrook Rd. 21236</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial dysrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral and Emphysema</b>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>11-19</b> 19 <b>83</b> , to <b>3-5</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3-3</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.															
22b. SIGNATURE <b>Harold B. Burr MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>3-5-87</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold B. Burr MD</b>						22e. ADDRESS <b>7220 Park Heights 21208</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-9-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>									
24. FUNERAL DIRECTOR NAME <b>John M. Weber &amp; Sons, INC.</b> ADDRESS <b>401 S. Chester St.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 06 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John M. Weber</b>							



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FOR  
STATE  
REGISTRAR

XC 054 21 613

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8

REG. NO.

06845

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P <sub>M</sub>	
MARVIN FLOYD RESS				MARCH 30, 1987		2:20 P <sub>M</sub>	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
MALE	WHITE	AUGUST 25, 1923		63 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WISCONSIN	U.S.A.			BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD	VA MEDICAL CENTER		ENGINEER				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		Anne Arundel	Severna Park			606 Center Drive 21146	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
WALTER RESS		BERTHA HAMUS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		WWII		Estelle R. R. Same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>BILATERAL PNEUMONIA</u> (c) <u>COPD</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CHRONIC BRAIN SYNDROME</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 15</u> , 19 <u>87</u> , to <u>MARCH 30</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>MARCH 30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>C.V.J. VERGHESE</u> DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
C.V.J. VERGHESE, M.D.				VA MEDICAL CENTER, FORT HOWARD, MD 21052			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		4-3-87		Crownsville Veterans		Crownsville Maryland	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Duda-Ruck Funeral Home of Dundalk		7922 Wise Ave. Dundalk, MD 21222		APR - 6 1987		Julia Duda-Ruck	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

048553 MAR 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06846	
1. DECEASED NAME (TYPE OR PRINT) <b>Bertine David Riegel</b>						2a. DATE OF DEATH MONTH <b>3</b> DAY <b>21</b> YEAR <b>87</b>			2b. HOUR <b>M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>24</b> YEAR <b>29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baynesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1734 Pin Oak Rd. 21234</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Underwriter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>			
13a. STATE <b>Maryland</b>						13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Baynesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>P.</b> LAST <b>Riegel</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Mildred</b> MIDDLE <b></b> LAST <b>Moyer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT <b>Mrs. Pauline Riegel</b>		ADDRESS <b>Same as 13c</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gastric Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <b>Neil Padgett</b> MD MPT						DEGREE <b>MD MPT</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-23-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Neil Padgett</b>						22e. ADDRESS <b>22 S Greentree Balto Md 2129</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/24/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN <b>Timonium</b> COUNTY <b>Balto.</b> STATE <b>Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b> ADDRESS <b>21204 1050 York Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove color photograph. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Muriel		MIDDLE Ada	LAST Riggle		2a. DATE OF DEATH		2b. HOUR
MURIEL		A.		RIGGLE		3-21-87		5 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		August 14, 1925		61		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Baltimore County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		St. Josephs Hospital #21204				Restaurant Cook		Food Services	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		Monkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16633 York Road, #21111	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
Charles Frank Carter				Elsie Blanche Hines					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT			
No				217-22-4825		Husband: George N. Riggle, 16633 York Rd. #21111			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fulminant bilateral pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coronary heart disease, Chronic active hepatitis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/21/87</u> to <u>3/27/87</u> , that (I) (we) lost sight of the body on <u>3/21/87</u> , and that in my (our) opinion death occurred on the date and hour and from the cause stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
MARK S. KAPLAN M.D.		16918 YORK RD MONKTON MD 21111							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Burial		25 Mar 1987		Dulaney Valley Mem. Pk.		Timonium, Balto. Co., Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Martin D. Lawson				MAR 26 1987		[Signature]			
26. NAME AND ADDRESS OF FUNERAL HOME									
Martin D. Lawson, 10 W. Padonia Road, Timonium									



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					87 06848 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HANNAH COREY RILEY					2a. DATE OF DEATH MONTH DAY YEAR MARCH 7, 1987			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 20, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2 Lake Manor Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2 Lake Manor Court 21210		
14. FATHER'S NAME FIRST MIDDLE LAST Harry Louis Robinson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Schroeder				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-12-6130		17. INFORMANT W. Pitts Riley		ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF THE PANCREAS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from JAN 19 80, to FEBR 19 87, that (1) (we) last saw the deceased alive on FEBR 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Miguel Karacuschansky				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Miguel Karacuschansky, M.D.				22e. ADDRESS 300 E. 33rd St. Baltimore, Md. 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/9/87		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212				ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this page. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event that medical attention might be required.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>SUZANNE H. RIPPEL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>03 26 '87</b>		2b. HOUR <b>5:45P</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 22, 1906</b>					
6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>		10. CITY OR TOWN OF DEATH <b>TOWSON</b>					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) <b>GEMC-6701 N. CHARLES ST.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>James A. Hooper</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha V. Pruett</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					
16b. SOCIAL SECURITY NO. <b>218-50-6649</b>		17. INFORMANT ADDRESS <b>1008 Malvern Ave.</b>		17. NAME AND ADDRESS <b>James A. Hooper, Jr. Towson, Md. 21204</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>MULTISYSTEM DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>03/14</b> , 19 <b>87</b> , to <b>03/25</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>03/25</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. EL DEFRAWI, M.D.</b>		DEGREE <b>MD.</b>		22c. DATE SIGNED <b>3/26/87</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. EL DEFRAWI, M.D.</b>		22e. ADDRESS <b>GEMC-6701 N. CHARLES ST.</b>		22f. PHYSICIAN'S SIGNATURE <b>Julia Davidson-Randall</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/28/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>					
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Co., Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>APR - 1 1987</b>		23f. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wierdefeld Home, Inc.</b>		ADDRESS <b>6500 York Rd.</b>		24. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>					

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 06850

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ELLEN LAST RITZ <i>MARY ELLEN RITZ</i>		2a. DATE OF DEATH MONTH DAY YEAR 3 25 87		2b. HOUR 2:40 A.M.	
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10 3 06	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS Hospice		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Glynn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine A. Murphy		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-70-7700		17. INFORMANT ADDRESS Henry C. Ritz - same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/10</i> 19 <i>80</i> , to <i>3/25</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>3/19</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>DR EDDIE Nakhuda</i>		DEGREE		22c. DATE SIGNED <i>3/25/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<i>DR EDDIE Nakhuda</i>		<i>STELLA MARIS Dulaney Valley Rd Towson MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-27-87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto., Md.	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		<i>Switzer-Rosen</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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MAR 26 1987





048583 MAR 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 06851

1. DECEASED NAME (TYPE OR PRINT) EVA Marie Thompson ROBERTS			2a. DATE OF DEATH MONTH DAY YEAR 03 24 87		2b. HOUR 12:30a M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 27 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse's Aid	12b. KIND OF BUSINESS OR INDUSTRY School System	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Baltimore 13c. CITY OR TOWN Cockeyville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 26 Ensor Avenue, 21030	
14. FATHER'S NAME FIRST MIDDLE LAST Jarrett Eugene Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Savenia Larena Kemp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-24-6927		17. INFORMANT ADDRESS Marjorie A. Frantz, 26 Ensor Ave., 21030	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>03/14</u> 19 <u>87</u> , to <u>03/24</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>03/24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>K. Golnik</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>3/24/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. GOLNIK, M.D.		22e. ADDRESS GBMC-6701 N. CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/26/87	23c. NAME OF CEMETERY OR CREMATORY Bosley United Meth.Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Phoenix Balto. Md.	
24. FUNERAL DIRECTOR NAME <u>Martin D. Lawson</u> ADDRESS _____		25a. DATE REC'D. BY REGISTRAR MAR 26 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and scribbles at the top of the page, including the word "SOME" and other illegible markings.

REAR OF

12/14/11

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Remind

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove scrapbook papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ruth M. ROBERTS</b>									
2a. DATE OF DEATH MONTH DAY YEAR <b>March 21, 1987</b>		2b. HOUR <b>8:20A M</b>							
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 14, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>67</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assembly Line</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Western Elect.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>August Martini</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lelia Haynes</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-01-8463</b>		17. INFORMANT ADDRESS <b>Thurman M. Roberts, Sr. 3428 McShane Way</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe end stage chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (he) (this hospital) attended the deceased from <b>March 11, 1987</b> to <b>March 21, 1987</b> , that (we) last saw the deceased alive on <b>March 21, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I and) (I and) view the body after death.									
22b. SIGNATURE <b>Joseph Kaplan</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/21/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph Kaplan, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-24-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk</b>				24b. ADDRESS <b>7922 Wise Ave. Dundalk, MD 21222</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAR 26 1987 [Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert this certificate into the envelope and place it in the envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 06853	
1. DECEASED NAME (TYPE OR PRINT) <b>EDNA Laura ROBINSON</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>3-20-87</b>				2b. HOUR <b>3:24 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 -21 -97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		IF UNDER 1 YEAR MONTHS DAYS <b>89</b> YRS		IF UNDER 24 HRS HOURS MIN. <b>3:24</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore Co.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian-Heritage Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stockperson</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1924 Queensway/ 21222</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Horace Stull</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Houck</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217/01/2060</b>		17. INFORMANT ADDRESS <b>Paul E. Flair (same as 13e.)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ACUTE CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CANCER OF BREAST</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>B. C. Veneracion Jr.</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/20/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. C. VENERACION JR.</b>						22e. ADDRESS <b>3401 DUNDALK AVE BALTO MD 21222</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/23/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Walter Brooks Bradley Inc., Balto., Md. 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 23 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John L. Anderson</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 06854

1. DECEASED NAME (TYPE OR PRINT) Mary Patricia ROBINSON			2a. DATE OF DEATH MONTH DAY YEAR March 24, 1987		2b. HOUR 1:30p M
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 4 1933	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Rossville 21237	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (INCLUDE STREET AND CITY, AND STREET ADDRESS) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher's Aid	12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OF TOWN Middle River	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2226 Coralhorn Rd. 21220
14. FATHER'S NAME FIRST MIDDLE LAST Mathew C. Schmidt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence G. Herbert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 30 8779		17. INFORMANT ADDRESS Maurice Robinson, Husband Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Left Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Small cell carcinoma of the lungs					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 1, 1987, to March 24, 1987, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 24, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (All witnesses must sign the body after death.)					
22b. SIGNATURE <i>Joseph Kaplan</i>		DEGREE M.D.		22c. DATE SIGNED 3/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Kaplan, M.D.		22e. ADDRESS 9000 Franklin Square Drive, 21237			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3/27/87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Towson, Md.		23e. DATE REC'D. BY REGISTRAR 26 1987			
24. FUNERAL DIRECTOR NAME Druzdinski Funeral Home PA 1407 Old Eastern Ave 21220		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06855				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William H. ROETH				7a. DATE OF DEATH MONTH DAY YEAR March 16, 1987				7b. HOUR 8:18 p.m.
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-15-1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., MD	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Jeweler		12b. KIND OF BUSINESS OR INDUSTRY Self Employed		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST William H. Roeth				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tiylee Malabre				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-03-5170A		17. INFORMANT ADDRESS Martha M. Roeth, 5915 Glen Oak Ave., 21214				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 9/2 } DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction (c) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Aspiration, Diabetes Mellitus, Progressive Azotemia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from March 11, 1987, to March 16, 1987, that (we) last saw the deceased alive on March 16, 1987, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.								
22b. SIGNATURE Jee-Jon Loh, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 16, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 9000 Franklin Square Drive, 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-20-87		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY Balto., MD		
24. FUNERAL DIRECTOR NAME John C. Miller, Inc., 6415 Belair Road, 21206				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06856

1 DECEASED NAME (TYPE OR PRINT) <b>William Stanley Romeka, Jr.</b>			2a DATE OF DEATH MONTH DAY YEAR <b>March 20, 1987</b>		2b HOUR <b>4:30 P</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>August 5, 1918</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>	
10 CITY OR TOWN OF DEATH <b>Upperco</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>17825 Falls Road, #21155</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wood Sculptor</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Art Work</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE <b>Maryland</b>	13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Upperco</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>17825 Falls Road, #21155</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Stanley Romeka, Sr.</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW 2</b>		16b SOCIAL SECURITY NO. <b>293-09-2398</b>	17 INFORMANT <b>Daughter:</b> ADDRESS <b>Highland, Maryland</b> <b>C. Jane Eichel, 7998 Brown Bridge Rd. 20777</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>N/A</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>N/A</b>					
19a DATE OF OPERATION <b>N/A</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>N/A</b> 19 <b>87</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>N/A</b>	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>19 87</b> to <b>3/20</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Peter Hinderberger</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>3/23/87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Peter Hinderberger, M.D.</b>		22e ADDRESS <b>4801 Yellow Wood Avenue, Baltimore, MD.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b DATE <b>2/23/87</b>	23c NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Pk.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Baltimore Co., MD.</b>	
24 FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>		25a DATE RECEIVED BY REGISTRAR <b>MAR 24 1987</b>			
25b REGISTRAR'S SIGNATURE <b>Julia Borden-Rodgers</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the staples. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

COOK COTTON FIBER  
MADE IN U.S.A.  
100-100000-100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06857	
1. DECEASED NAME (TYPE OR PRINT) ANNA ROUGEN				2a. DATE OF DEATH MONTH DAY YEAR MARCH 7, 1987				2b. HOUR 4:21PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAY 11, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6946 MILBROOK PARK DR. APT. 2B (21215)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6946 MILBROOK PARK DR. #2B (21215)			
14. FATHER'S NAME FIRST MIDDLE LAST AARON RAININ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLY FRANKIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-16-1628		17. INFORMANT ADDRESS MRS. SELMA KATZ 3802 BARTWOOD RD. (21215)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, antedated C.V. disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> , to <u>January</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>January</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Julius H. Goodman</u>				DEGREE MD				22c. DATE SIGNED 3/8/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Julius H. Goodman</u>				22e. ADDRESS <u>11 Slade Ave Apt 504 21208</u>							
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE MAR. 8, 1987		23c. NAME OF CEMETERY OR CREMATORY CHERNIGOVER CEM		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE, BALTO., MD.			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD. (21215)						25a. DATE REC'D. BY REGISTRAR MAR 11 1987		25b. REGISTRAR'S SIGNATURE <u>W. A. Henderson-Randall</u>			

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046704

FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 06858

1. DECEASED NAME (TYPE OR PRINT) <b>Ethel Marie Rue</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>March 6, 1987</b>		2b. HOUR <b>5:40 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>June 1, 1909</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. STREET ADDRESS / ZIP CODE <b>1310 D E. Belvedere Ave. 21239</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ulysses Highley Buler</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith White</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-54-0159</b>		17 INFORMANT ADDRESS <b>James C. Rue Pleasant Plains Rd. 21204</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic breast cancer</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year.</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>11-28</b> , 19 <b>86</b> , to <b>3-6</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>3-6</b> , 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>George E. Lowe</b>		DEGREE <b>For Dr. Koushki</b>		22c. DATE SIGNED <b>3-9-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George E. Lowe, M.D.</b>		22e. ADDRESS <b>3703 Belair Rd. Baltimore, MD 21213</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>03/10/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 09 1987</b>			
24 FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
JAMES BENNING RUSSELL					03 26 '87					4:48P M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	CAU		July 3, 1912		74		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Alabama	U.S.A.				BALTIMORE COUNTY MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
TOWSON	GMC-6701 N. CHARLES ST.				Mailman		U.S. Postal				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Md.					Balto.		Reisterstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE		21136		
FIRST MIDDLE LAST Thomas Benning Russell					FIRST MIDDLE LAST Edna Louise Dooley		15109 Dover Rd.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
Yes					1932-1935		578-01-0095		Doris Russell Reisterstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
CORONARY ARTERY DISEASE											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 03/19 19 87, to 03/26 19 87, that (I) (we) last saw the deceased alive on 03/26 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles Emala						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 03/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES EMALA, M.D.						22e. ADDRESS GMC-6701 N. CHARLES ST.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			Mar. 30, 1987		Pleasant Grove Cem.		Upperco, Balto., Md.				
24. FUNERAL DIRECTOR H. E. Ebbhardt						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Manchester, Md.						MAR 27 1987		Lidia Gordon-Ludlow			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
SERGE N. RUTKOVSKI								3 7 87	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		White		11 29 60		86		4:00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 1 YEAR MONTHS DAYS	
Estonia		USA				BALTIMORE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. IF UNDER 24 HRS. HOURS MIN.	
Baltimore Md		St Joseph Hosp		Construction		Building			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS		13e. ZIP CODE	
MD. Balto		Howson				800 South Heely Ave		21204	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Nicholas Rutkovsky		Elizabeth Rutron		NO		578-22-3827		Patricia Martin #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) _____									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
Adels El-Hennawy MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				3-7-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
ADELS EL-HENNAWY		S J H							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
CREMATION		3/8/87		CEDAR HILL		SOUTHARD P.G. MD			
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
TAYLOR FUNERAL CHAPEL ANNAPOLIS, MD.		MAR 12 1987		Julia D. ...					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		8 REG. NO. 06861	
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH MYERS SANDERS		2a. DATE OF DEATH MONTH DAY YEAR 7 HOUR MARCH 27 1987 7:30 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 19 1894	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. AGE (IN YEARS LAST BIRTHDAY) 93 YRS	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
13a. STATE Md	13b. COUNTY Balto	13c. CITY OR TOWN Charlesbrooke	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles O MYERS	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Spicer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 217 48 1657	17. INFORMANT ADDRESS John E. Sanders Sr. Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO - PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 Hours</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/10</u> , 19 <u>80</u> , to <u>3-27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3-27</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Dr. Eddie NAKHODA</u>	DEGREE M.D.	22c. DATE SIGNED 3-27-87	22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Eddie NAKHODA M.D.
22e. ADDRESS 2300 Dulaney Valley Rd. Towson 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/30/1987	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home		25a. DATE REC'D. BY REGISTRAR APR - 1 1987	
ADDRESS 6500 York Rd.		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall	



CLARENCE M. JAMES  
MAY 22 1962

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 REG. NO. 06862		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LENA SARUBIN		2a. DATE OF DEATH MONTH DAY YEAR MARCH 9, 1987		2b. HOUR 1:30 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAY 15, 1898 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MILFORD MANOR NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STOREKEEPER		12b. KIND OF BUSINESS OR INDUSTRY DRUG STORE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. MARYLAND 13c. COUNTY BALTIMORE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6622 VINCENT LANE ( 21215)			
14. FATHER'S NAME FIRST MIDDLE LAST SOLOMON DUNNER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRIEDA UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-26-2926		17. INFORMANT ADDRESS MARVIN BARRASH 1 SAMWOOD CT. (21208)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Larsine Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Organic Brain Disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Organic Brain Disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>May 20</i> 19 <i>82</i> to <i>March 9</i> 19 <i>87</i> , that (I) <del>we</del> <i>we</i> saw the deceased alive on <i>March 9</i> 19 <i>87</i> , and that in (my) <del>our</del> <i>our</i> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <i>we</i> (did) <del>(did not)</del> view the body after death.									
22b. SIGNATURE <i>Manuel Levin</i> M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN				22e. ADDRESS 6101 PARK HEIGHTS AVE. BALTO., MD. (21215)					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 3/10/87		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CONG. CEM		23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN, BALTO., MD.			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)				25a. DATE REC'D. BY REGISTRAR MAR 11 1987 REGISTRAR'S SIGNATURE <i>John Decker-Randall</i>					

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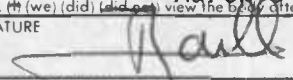
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8706863

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nina M. SAVILLE			2a. DATE OF DEATH MONTH DAY YEAR March 9, 1987		2b. HOUR 11:35p <sub>M</sub>
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 07-28-1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Kennie H. Ratcliff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Walker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 232-26-0781		17. INFORMANT ADDRESS Mr. Jules B. Saville, Baltimore, MD-husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (H) (this hospital) attended the deceased from <u>December 29</u> , 19 <u>86</u> , to <u>March 9</u> , 19 <u>87</u> , that (H) (we) last saw the deceased alive on <u>March 9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 03/09/87	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Adam Faili, M.D.		22e. ADDRESS 9000 Franklin Sq. Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03-12-1987		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		23d. LOCATION CITY OR TOWN COUNTY STATE Fort Ashby Mineral WV		25a. RECEIVED BY DEPT. OF HEALTH MAR 16 1987	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all non-papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
REG. NO. 06864										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary M. Sandaliato					2a. DATE OF DEATH MONTH DAY YEAR 3-6-87					2b. HOUR 8:05 P.M.
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 2, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.
9a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY MILEO					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE NOTO					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO. 216-12-6565		17. INFORMANT ADDRESS ROSEANN S. NELSON 1724 WESTON AVE. 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive Pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (b) Chronic congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE DEGREE Adel S. El-Hennawy M.D.					22c. DATE SIGNED 3-6-87			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adel S. El-Hennawy		
22e. ADDRESS ST H.										
23a. BURIAL, CREMATION, REMOVAL ENTOMBMENT			23b. DATE MARCH 10, '87		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY, MD.		
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON 8521					25a. DATE REC'D. BY REGISTRAR MAR 09 1987			25b. REGISTRAR'S SIGNATURE John D. Anderson		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner should be notified (checked).

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					8 REG. NO. 06865						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE K SCHAPIRO					2a. DATE OF DEATH MONTH DAY YEAR 3-18-87			2b. HOUR 5 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-22-1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. CITY OR TOWN BALTIMORE					13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 11 SLADE AVE., APT. 801 #21208				
14. FATHER'S NAME FIRST MIDDLE LAST WOLF KRESS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY STOCKER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-32-2027		17. INFORMANT MR. BERNARD SCHAPIRO APT. 801 11 SLADE AVE. BALTO., MD 21208							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION -</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PREVIOUS MYOCARDIAL INFARCTION - DIABETES MELLITUS</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-17-1987</u> to <u>3-18-1987</u> , that (I) (we) lost saw the deceased alive on <u>3-18-1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>R. Depestre</u> MD 22c. DATE SIGNED 3-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. DEPESTRE			22e. ADDRESS BALTIMORE COUNTY GENERAL HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 20, 1987		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD				
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR MAR 24 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining pages to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louise Rexel Scheffel</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3-10-87</b> 3 10 87					2b. HOUR <b>11 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 8, 1907</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1215 BRANDFORD ROAD</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13e. STREET ADDRESS / ZIP CODE <b>1215 BRANDFORD ROAD 21228</b>						
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>VINCENT McCLAIN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA KEXEL</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>213-20-4526</b>		17. INFORMANT ADDRESS <b>G. DONALD SCHEFFEL 301 BENTON AVENUE LINTHICUM, MD. 21090</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST - SUDDEN DEATH</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>Hypertension</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>February 3, 1987</b> to <b>present</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>February 5, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Damian E. Birchess, MD.</b>					DEGREE <b>MD.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/12/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAMIAN BIRCHESSE, MD.</b>					22e. ADDRESS <b>5411 OLD FREDERICK RD. 21229</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/16/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKE VIEW MEMORIAL PK.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>SYKESVILLE MARYLAND</b>			
24. FUNERAL DIRECTOR <b>LEON M. &amp; RUSSELL C. WITZKE FUNERAL HOMES P.A.</b>					25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE <b>MAR 13 1987 Julia Davidson-Russell</b>						
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228											

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Ruth E. Schlimm E			2a. DATE OF DEATH 3-17-87			2b. MONTH DAY YEAR 3 17 87			2c. HOUR 2:35 P.M.
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 12 27 90		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD			
10. CITY OR TOWN OF DEATH BALT Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easipoint NSG Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1056 North Pt. Rd. 21222	
14. FATHER'S NAME George				15. MOTHER'S MAIDEN NAME Harriett					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no/				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-24-5376		17. INFORMANT ADDRESS Susan Stealy 22 Eastship Rd. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Rt stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Week</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>3:30 P.M. 3 17 1987</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> , 19 <u>87</u> , to <u>3/17</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Paul Walk Gorm</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3/17/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul Walk Gorm</u>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/20/87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Connelly Funeral Home of Dundalk				25a. DATE REC'D. BY REGISTRAR MAR 20 1987		25b. REGISTRAR'S SIGNATURE <u>John F. ...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed (within 24 hours after death) by a physician who is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon paper (pages 1, 2, and 3) and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased's body be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 06869							
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD F. MIDDLE SCHULTZ, SR.</b> <b>Edward F. Schultz</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3/13/87</b>				2b. HOUR <b>10 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 3 04</b> <b>2 3 84</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>I.N.A.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BRADSHAW</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>11200 Pfeffer Rd. 21201</b> <b>11200 Pfeffer Rd 21021</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK SCHULTZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SOPHIE UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>215-03-3846</b> <b>215-03-3846</b>		17. INFORMANT ADDRESS <b>PAUL SCHULTZ (SON) 3623 NORTHWAY DR. 21234</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/4</b> , 19 <b>84</b> , to <b>3/13</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jeffrey N. Posovar, MD</b> THE PHYSICIAN'S NAME (TYPE OR PRINT)				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/13/87</b>	
22d. ADDRESS <b>1518 Pot Spring Rd, Lutherville 21093</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/16/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>			
24. FUNERAL HOME <b>SCHEIDTKE FUNERAL HOME, INC.</b> NAME ADDRESS <b>9705 Belair Rd., Balto. Md. 21236</b>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAR 17 1987</b>			

MEDICAL CERTIFICATION



047550 MAR 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 06870

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth Schwartz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 11 1987</b>		2b. HOUR <b>1811 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>December 18 1916</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Baltimore County General Hospital</b>		12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS & ZIP CODE <b>843 Windsor Mill Road 21207</b>	
14. FATHER'S NAME <b>Benjamin F. Cavey</b>		15. MOTHER'S MAIDEN NAME <b>Lula Pruitt</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-18-9558</b>		17. INFORMATANT <b>Mr. George W. Schwartz</b> ADDRESS <b>6103 Windsor Mill Road Baltimore Maryland 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Obstructive Lung Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>3-11-87</b> , to <b>3-11-87</b> , that (I) (we) last saw the deceased alive on <b>3-11-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Allan J. Chincus M.D.</b>		DEGREE		22c. DATE SIGNED <b>3-11-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allan J. Chincus</b>		22e. ADDRESS <b>Balt. County General Hosp</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>3/14/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Park</b>		23d. LOCATION <b>Sykesville Carroll Maryland</b>
24. FUNERAL DIRECTOR NAME <b>LeRoy Byers</b> ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 16 1987</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					87 REG. NO. 06871				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>James I Schwartz</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>3-3-1987</u>			2b. HOUR <u>1926</u> M	
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>07-05-1919</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>NORTH CAROLINA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE COUNTY</u> MD.			
10. CITY OR TOWN OF DEATH <u>RANDALLSTOWN</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore County Gen'l Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>BALTIMORE</u>		13c. CITY OR TOWN <u>RANDALLSTOWN</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>5432 OLD COURT 21133</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>MOSES SLOSSBERG</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>JULIETTE NAMAN</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>212-16-3980</u>		17. INFORMANT ADDRESS <u>HOWARD ROBINS 11711 TERRYTOWN DR REISTERSTOWN, MD 21136</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Infarction wall M.I.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-3</u> , 19 <u>87</u> , to <u>3-3</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3-3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Allen J. Chincus M.D.</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>3-3-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Allen J. Chincus M.D.</u>		22e. ADDRESS <u>Balt. County General Hosp</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>3/5/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETH TFILOH</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>WOODLAWN BALTIMORE MD.</u>			
24. FUNERAL DIRECTOR <u>HEBREW MENDIAL F.H. 1100 REISTERSTOWN RD</u>						25a. DATE REC'D. BY REGISTRAR <u>MAR 04 1987</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rodman</u>	

THE STATE OF NEW YORK  
COUNTY OF ALBANY

1810

EXHIBIT A  
1810



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

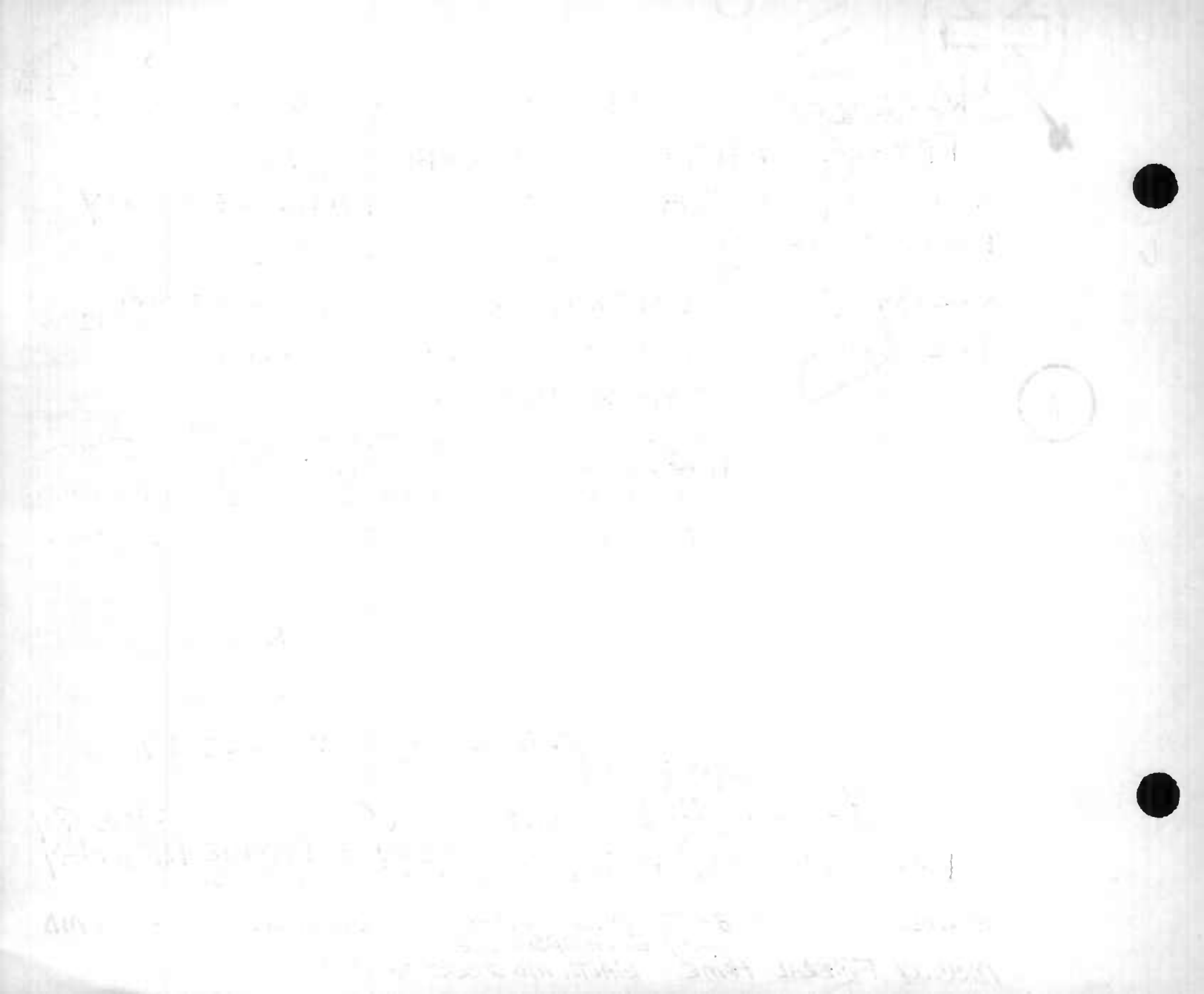
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonized parts. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 may be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, in which the funeral director must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REC. NO. 06872

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET SEEBOLD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03-25-87</b>			2b. HOUR P.M. <b>5:25</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07-30-1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>ENGLISH COUNSEL</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2728 Daisy Ave., 21227</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		
13a. STATE <b>MARYLAND</b>			13b. CITY OR TOWN <b>BALTIMORE</b>			13c. STREET ADDRESS / ZIP CODE <b>2027 ANNA POLS ROAD, BALTIMORE, Md. - 21230</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK GOODRICH</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA HEINLINE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>217-263482</b>			17. INFORMANT ADDRESS <b>Mr. Harry G. Seebold Same as #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEVERE CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF <b>HYPERTENSIVE ARTERIO-SCLEROTIC</b> (b) <b>CARDIO-VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF <b>DIABETES MELLITUS.</b> (c) <b>5 year</b> <b>10 year.</b> <b>2 year.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 16</b> 19 <b>87</b> , to <b>March 25</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3/17/87</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Harjit Singh</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/25/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARJIT SINGH M.D.</b>			22e. ADDRESS <b>5507-E RITCHIE HIGHWAY BALTIMORE, Md. - 21225</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3-28-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MemPk</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE Howard MD</b>		
24. FUNERAL DIRECTOR NAME <b>McGully Funeral Home</b>			24b. ADDRESS <b>237 E PATAPSCO AVE BALTE, MD 21225</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8706873  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE M. SEIM		2a. DATE OF DEATH MONTH DAY YEAR 3-6-87		2b. HOUR 8:05 A.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8-22-99	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVERVIEW NURSING CENTRE		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 833 CHESACO AVE. 21237			
14. FATHER'S NAME FIRST MIDDLE LAST ALOIS MASEK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KAROLINE HARTEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-09-6120		17. INFORMANT HENRY SEIM (SON) 3040 LAVENDER AVE. 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior wall Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Coronary Artery Disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Michael R. [Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/9/87		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEM.	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.					
24. FUNERAL DIRECTOR NAME ADDRESS SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, page 1, and 2, to the funeral director. Page 4 may be retained by the funeral director. If item 21 is marked or item 18 shows injury, or other trauma, the medical examiner must be notified.

159035300

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE BLY SEKINGER					2a. DATE OF DEATH MONTH DAY YEAR March 28, 1987			2b. HOUR 5:15A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 8, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, <del>XXXXXX</del> Co. MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney-Towson N.H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ----		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 2405 Hamilton Ave. 21214	
14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Meek					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phoebe Ann Hitchcock					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-12-6475		17. INFORMANT ADDRESS \$P. Sekinger 2405 Hamilton Ave. 21214 Balto., Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD with</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Remote CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>25 Nov. 1986</u> to <u>28 March 1987</u> , that (I) (we) saw the deceased alive on <u>27 March 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.										
22b. SIGNATURE <u>Charles F. O'Donnell</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3/30/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. O'Donnell				22e. ADDRESS 7501 York Road 21204						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-31-87		23c. NAME OF CEMETERY OR CREMATORY Jessops		23d. LOCATION CITY OR TOWN COUNTY STATE Sparks Balto Md				
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home				ADDRESS 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR APR - 1 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		



046591

MAR 11 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

06875

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Michael Selepack JR.</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>6</b> YEAR <b>87</b>			2b. HOUR <b>8 25 pm</b>					
3. SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>22</b> YEAR <b>12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Rossville</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired- Board of Ed.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>944 Woodlynn Road 21221</b>			
14. FATHER'S NAME FIRST <b>Michael</b> MIDDLE <b>Selepack</b> LAST <b>Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Katherine</b> MIDDLE <b>Pacolyak</b> LAST <b>Pacolyak</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>208-05-6357</b>		17. INFORMANT ADDRESS <b>Eugene Selepack 946 Woodlynn Rd. 21221</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>- Cancer lung.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>- Metastatic cancer lung to Brain.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/4/87</b> to <b>3/6/87</b> , that (I) (we) last saw the deceased alive on <b>3/6/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Kitin-M. TUN</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/9/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kitin-M. TUN</b>			22e. ADDRESS <b>1006 Taylor Avenue md 21204</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/10/87</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Middle River Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Connelly Funeral Home</b>						ADDRESS <b>300 Mace Ave. 21221</b>			25a. DATE REC'D BY REGISTRAR <b>MAR 10 1987</b>		
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEDENT'S NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE OF DEATH MONTH DAY YEAR		26 HOUR A.M.	
ROBERT		FRANKLIN		SEYMOUR		JR.		3 10 87		4:35 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		MARCH 24 1895		91 YRS.					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD.		U.S.A.				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		EASTPOINT NURSING CENTER		RAILROAD MAN		B & O RAILROAD					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		13f. APT. NO.	
MD.				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4320 CLAREWAY AVE. 21213		Apt. 5N	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
ROBERT FRANKLIN SEYMOUR		ANNA SEYMOUR		YES WW I		217-01-6875		ROBERTA WHITMORE		7424 BAY FRONT RD. BALTO. 21219	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uroperis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>UTI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Alimentary - H/O Symptom - H/O Angina - Blindness</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 5</u> 19 <u>87</u> to <u>March 10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
<u>B. Matos, M.D.</u>						3/10/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
B. MATOS, M.D.		21 Cranbrook Rd Cockeysville Md. 21031									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		3/12/87		BALTO. NAT'L		BALTIMORE		MD.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213		MAR 13 1987		<u>John D. ...</u>							



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06871  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY K. SHANE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3. 9 87</b>		2b. HOUR <b>4:10 P.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10. 22. 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. County.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Kasal</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Valenta</b>		13e. STREET ADDRESS / ZIP CODE <b>4404 Wynn Rd. 21236</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-16-2133A</b>		17. INFORMANT ADDRESS <b>Margaret M. Shane -731 Camberley Circle 21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Indeterminate CHF.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>As in (a).</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>As in (a).</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Renal failure + Acute pulmonary embolism; evidence not specified.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/21/87 19 87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/21/87</b> , 19 <b>87</b> , to <b>5/19</b> , 19 <b>87</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>3/19/87</b> , 19 <b>87</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L.R. Awtrey, M.D.</b>		DEGREE		22c. DATE SIGNED <b>3/19/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>120 S. Green St. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-12-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>		24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b> ADDRESS <b>1050 York Rd. Towson, Md. 21204</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

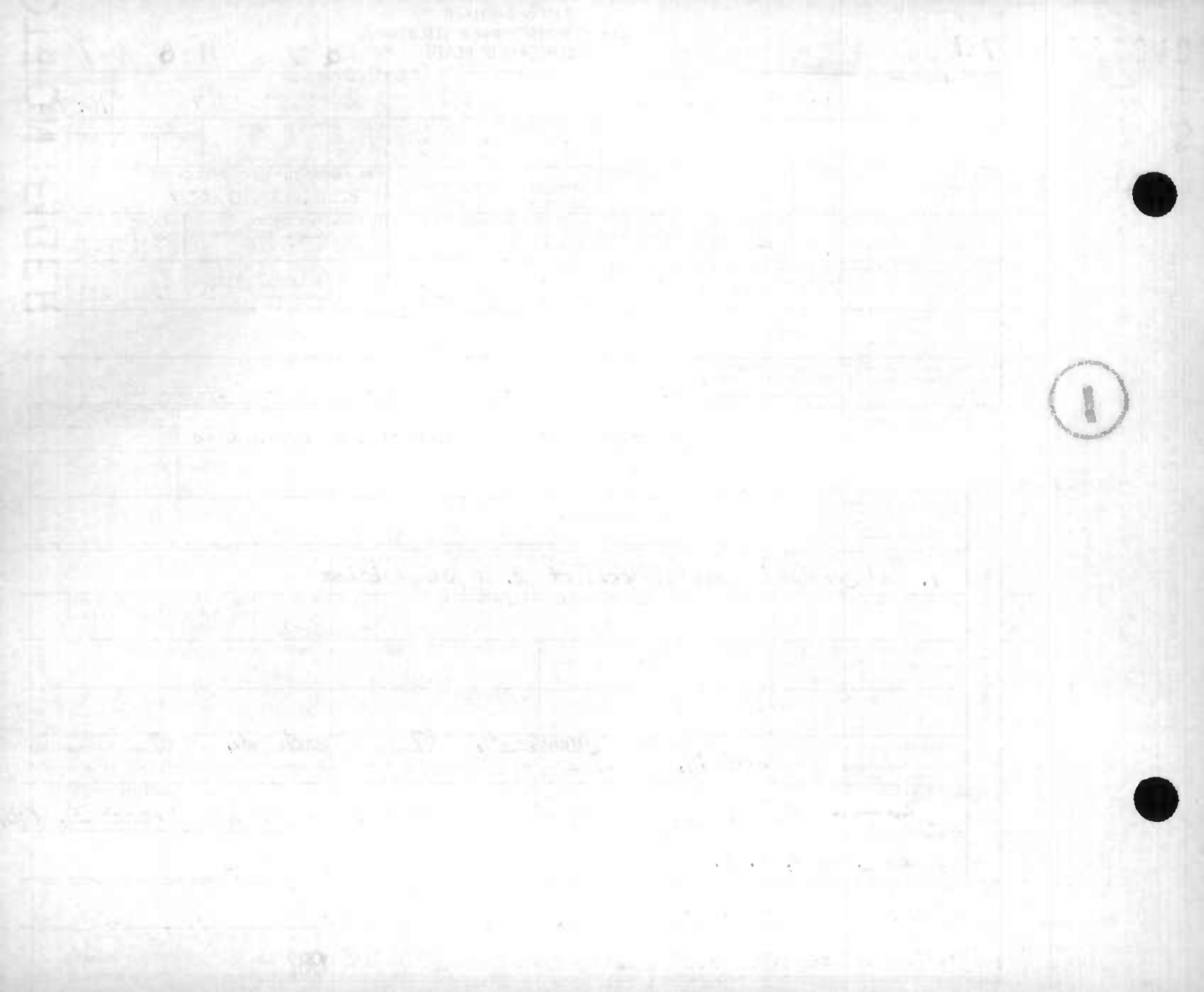
MAR 10 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH RIGGS SHIPLEY					2a. DATE OF DEATH MONTH DAY YEAR MARCH 20, 1987			7b. HOUR 10:30 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 12 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SUMMIT NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND ANNE ARUNDEL SEVERNA PARK					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 104 TRAILING IVY LANE 21146		
14. FATHER'S NAME FIRST MIDDLE LAST ACKLIN RIGGS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-22-6774		17. INFORMANT ADDRESS JEANNE S. GILDARD 104 TRAILING IVY LANE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure Acute Pneumonitis</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>1. Old Cerebral Vascular Accident 2. Hypothyroidism</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>January 20, 1987</i> to <i>March 20, 1987</i> that (I) (we) last saw the deceased alive on <i>March 19, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James E. Rowe M.D.</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>March 20, 1987</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James C. Rowe, M.D.</i>					22e. ADDRESS <i>413 COMMONWEALTH 21228</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE <i>03/21/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BALTO.-WASH. CREMATORY LAUREL</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>P.G. MARYLAND</i>		
24. FUNERAL DIRECTOR <i>AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD</i>					25a. DATE REC'D. BY REGISTRAR <i>MAR 23 1987</i>		25b. REGISTRAR'S SIGNATURE <i>James C. Rowe</i>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. The permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, a medical examiner must be notified of one.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 87 06879

1. DECEASED NAME (TYPE OR PRINT) <b>LYDIA T Shortridge</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>3 15 87</b>		2b. HOUR <b>630 PM</b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 21 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH'S HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>White Marsh</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elias Anderson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lina Nunchester</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>233-96-1802</b>		17. INFORMANT ADDRESS <b>Alice Franzello Daughter same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>20 yrs</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 min</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <b>Congestive Heart Failure</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>87 3/15 19 87</b> to <b>3/15 19 87</b> , that (I) (we) last saw the deceased alive on <b>3/15 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Duane Smoot</b>		22c. ADDRESS <b>7620 York Road Towson Md 21204</b>		22d. DATE SIGNED <b>3/15/87</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Duane Smoot</b>		22f. ADDRESS <b>7620 York Road Towson Md 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wallace Memorial</b>	
23d. LOCATION (CITY OR TOWN) <b>Clintonville</b>		23e. COUNTY <b>Greenbrier</b>		23f. STATE <b>W. Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		25. DATE RECEIVED BY REGISTRAR <b>3/15/87</b>			
26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		27. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP

OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS



U. S. DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
WASHINGTON, D. C.  
1900

THE CENSUS OF 1900  
WAS TAKEN ON APRIL 15, 1900  
AND THE RESULTS WERE  
PUBLISHED IN THE  
MONTH OF SEPTEMBER, 1900.

THE CENSUS OF 1900  
WAS TAKEN ON APRIL 15, 1900  
AND THE RESULTS WERE  
PUBLISHED IN THE  
MONTH OF SEPTEMBER, 1900.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation must be conducted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Albert William SHOUP			2a. DATE OF DEATH MONTH DAY YEAR March 30, 1987				2b. HOUR 11:30p M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 27 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN) Butler, Pa.		9b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Franklin Sq. Hospital				12a. USUAL OCCUPATION (If deceased followed a profession or trade) Chief Engineer		12b. KIND OF BUSINESS OR INDUSTRY Dairy Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3517 Dahlia Lane 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Albert John Shoup				15. MOTHER'S MAIDEN NAME MIDDLE LAST Elva Holliday					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 172 12 0921		17. INFORMANT ADDRESS Marion S. Shoup, Wife Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiovascular Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septic Shock</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Old anterior myocardial infarction</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <u>N</u> (this hospital) attended the deceased from <u>March 27</u> , 19 <u>87</u> , to <u>March 30</u> , 19 <u>87</u> , that <u>N</u> (we) last saw the deceased alive on <u>March 30</u> , 19 <u>87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>N</u> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Adam Fail</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>3/30/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adam Fail, M.D.				22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237					
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>4/3/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holly Hill Memorial Gardens</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Smazdzinski Funeral Home PA 1407 Old Eastern Ave</u>				25a. DATE REC'D BY REGISTRAR <u>APR 2 1987</u>					

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046699 MAR 17 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 06881

1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy Irene Shupe</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 4, 1987</b>			2b. HOUR <b>9:00 P.M.</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 30, 1908</b>		6 AGE (IN YEARS (LAST BIRTHDAY)) <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10 CITY OR TOWN OF DEATH <b>Dundalk</b>		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8200 Longpoint Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Jessiah Keller</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Yockey</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-50-6430</b>		17 INFORMANT ADDRESS <b>Ella P. Barbieri 2409 Perring Woods Rd.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular arrest.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARSCVD &amp; Aortic stenosis</b>							<b>15 yrs</b>
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>87</b> , to <b>Feb</b> , 19 <b>87</b> , the <b>0</b> (we) lost saw the deceased alive above <b>Feb 24</b> , 19 <b>87</b> , and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above <b>Feb 24</b> , 19 <b>87</b> .							
27b. SIGNATURE <b>Alan N. Dennis</b>				DEGREE <b>M.D.</b>		27c. DATE SIGNED <b>3/5/87</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN N. DENNIS, M.D.</b>				27e. ADDRESS <b>7120 North Point Road, Balto., MD 21219</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-7-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk</b> ADDRESS <b>7922 Wise Ave. Dundalk, MD 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 09 1987</b>			
25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, state any injury, or other traumatic event, the medical examiner must be notified of cause.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the corse-box paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or disease, or other event, the medical examiner must be notified of case.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eugene T. Siewierski					2a. DATE OF DEATH MONTH DAY YEAR 3-20-87		2b. HOUR 3 P M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr. 14, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Aloysius Siewierski					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Kamuda					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Martha E. Siewierski, Wife, same as above		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Bulbar stroke DUE TO, OR AS A CONSEQUENCE OF (c) Elect. IMBALANCE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple pressure ulcer										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3-15, 19, to 3-20, 19, that (I) (we) last saw the deceased alive on 3-20, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE EBRAHIM IPAKCI				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-20-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 7401 OSLER DRIVE 21204						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/24/87		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.				
24. FUNERAL DIRECTOR NAME SCHMUNEK FUNERAL HOME, Balto, Md. 21213				25a. DATE REC'D. BY REGISTRAR MAR 24 1987		25b. REGISTRAR'S SIGNATURE James J. Anderson-Randall				



*[Faint, illegible handwriting on lined paper]*

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# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

 1 - FOR  
STATE  
REGISTRAR

REG. NO. 06383

DECEASED NAME (TYPE OR PRINT) <b>TYLER James SILVIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 6 87</b>		2b. HOUR <b>4:14 p.m.</b>
1. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 6, 1987</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>3 6 87</b>	IF UNDER 1 YEAR HOURS MIN. <b>11 54</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TOWSON</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -----		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Aberdeen</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>923 Walker Street/21001</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Douglas Shawn Silvis</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Jean Zisa</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>	17. INFORMANT ADDRESS <b>Douglas S. Silvis, Same As Above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory distress syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/6</b> , 19 <b>87</b> , to <b>3/6</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>3/6</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Leslie L. Walters</i>				22c. DATE SIGNED <b>3/7/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LESLIE L. WALTERS, M.D.</b>				22e. ADDRESS <b>6701 N. Charles Street, Towson MD 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal/Cremation</b>		23b. DATE <b>Mar. 8, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>R.A. Ferris and Co.</b>	
24. FUNERAL DIRECTOR NAME <b>Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>West Chester, Chester, Penna.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1987</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.



047499 MAR

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06884

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Marion H. Simon					03-14-87					10 <sup>35</sup> P.M.
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White	11-27-00		86 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
Poland	U.S.A.			Balto. County						MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore	Eastpoint Nursing Home		Unknown							
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE						
Md.		Balto.		4700 Harford Rd. 21214						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
Michael		Antionette		no		058-12-1394		Lucille Mudd		6925 University Drive 21220
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
9293		Sepsis		Multiple bedsores				days weeks months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
CBS - Aortic aneurysm - Normal aortic aneurysm - Rtlup fract. - old										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK										
22a. I certify that (I) (this hospital) attended the deceased from Nov. 13, 1953, to March 14, 1957, that (I) (we) last saw the deceased alive on March 12, 1957, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
B. W. Ats, M.D.						3/11/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
BIENVENIDO R. MATOS, M.D.		21 Cranbrook Rd Cockeysville Md 21030		Cremation		3/16/87		Security Process		Baltimore Maryland
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Connolly F.H.		300 NACE AVE		MAR 17 1987		Julia Sander-Randall				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return it to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene guide to burial, cremation, or removal. IMPORTANT: If marked or had 18 above any injury, or other traumatic event, it should be marked as such.

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-part of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06885	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH A. SIPE					2a. DATE OF DEATH MONTH DAY YEAR MARCH 25, 1987			2b. HOUR 8:45A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 13, 1910		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 77		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH 21234		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8225 OAKLEIGH ROAD 21234				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8225 OAKLEIGH RD. 21234			
14. FATHER'S NAME FIRST MIDDLE LAST WILT ON A. MELLOTT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ORA SOUDERS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 218-09-4886		17. INFORMANT ADDRESS JACK SIPE 3627 E. JOPPA RD. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gas Cell Concussion 7th lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>86</u> , to <u>March</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Arthur A. Serpick</u>					DEGREE MD			22c. DATE SIGNED 3/25/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR A. SERPICK, M.D.					22e. ADDRESS 7620 YORK ROAD 337-1205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MARCH 28, '87		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MARYLAND				
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON					25a. DATE RECEIVED BY REGISTRAR MAR 26 1987		25b. REGISTRAR'S SIGNATURE <u>William E. Johnson</u>				



For all items to be

and to be

and to be



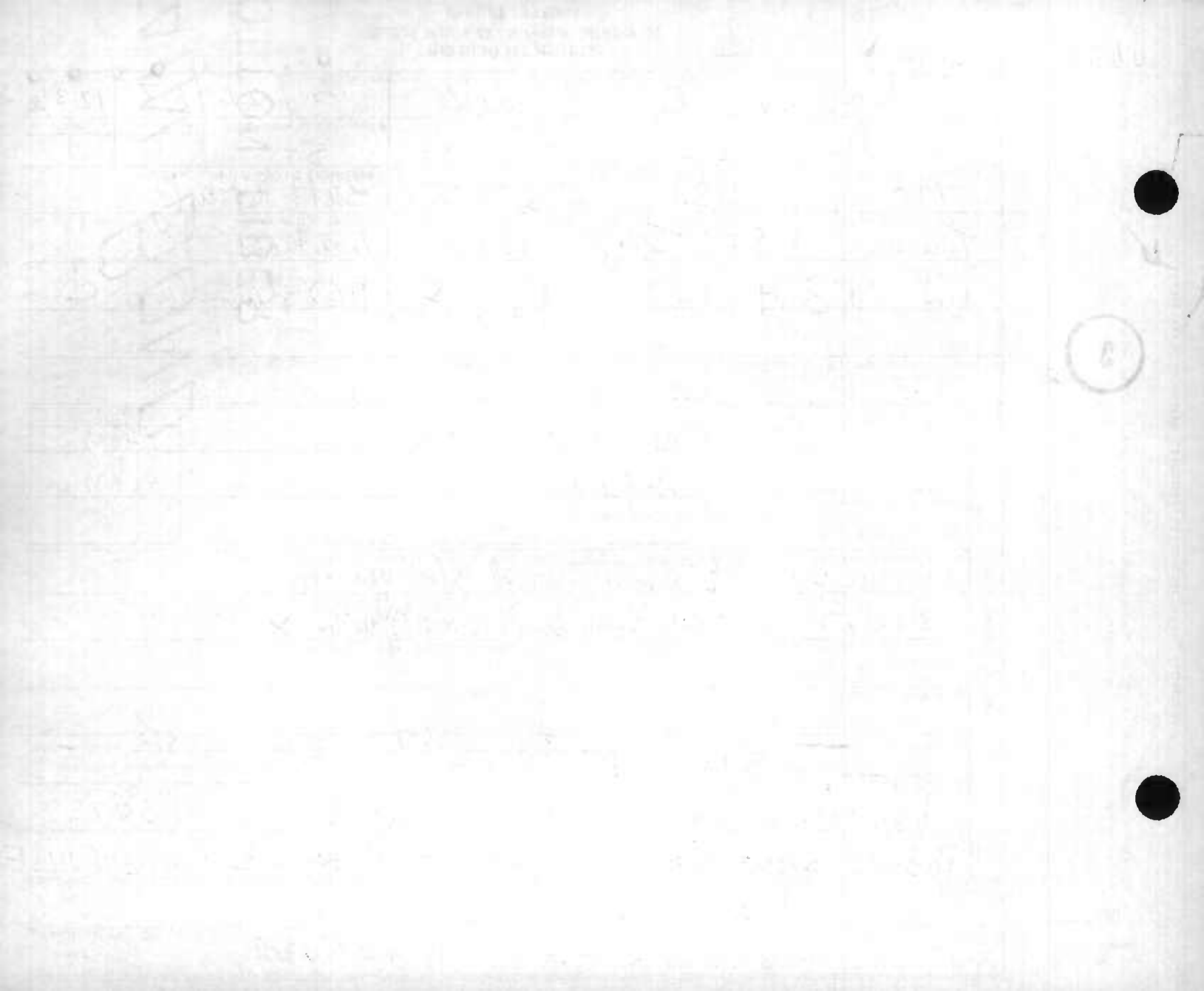
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) <b>Lorraine C Sladek</b>		20. DATE OF DEATH MONTH <b>3</b> DAY <b>26</b> YEAR <b>87</b>		2b. HOUR <b>12 3/4 PM</b>	
3. SEX <b>female</b>	4. RACE <b>can</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>1</b> YEAR <b>32</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	IF UNDER 1 YEAR MONTHS <b>5</b> DAYS <b>10</b> HOURS <b>15</b> MIN.	
7a. BIRTHPLACE COUNTRY <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Joseph Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>waitress</b>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MD</b>	13b. COUNTY <b>Balt</b>	13c. CITY OR TOWN <b>Glen Arm</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE <b>11623 Camp Cone Rd 21057</b>	
14. FATHER'S NAME FIRST <b>Andrew</b> MIDDLE <b>Kocent</b> LAST <b>Kocent</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Tillie</b> MIDDLE <b>Kuchta</b> LAST <b>Kuchta</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-30-8734</b>		17. INFORMANT <b>Tillie Kocent</b> ADDRESS <b>11623 Camp Cone Rd. 21057</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiogenic shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>depos</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic partial small bowel obstruction</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>48 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>chronic partial small bowel obstruction</b>					
19a. DATE OF OPERATION <b>3/24/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>chronic partial small bowel obstruction</b>		20a. AUTOPSY? <b>NO</b>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>3/25</b> 19 <b>87</b> , to <b>3/26</b> 19 <b>87</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>3/25</b> 19 <b>87</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <b>did not</b> view the body after death.					
22b. SIGNATURE <b>Robert Stone Baxt</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/27/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT STONE BAXT</b>		22e. ADDRESS <b>54 SCOTT ADAM RD COCKEYSVILLE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-30-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garden of Faith</b>	
23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD</b> STATE <b>MD</b>		24. FUNERAL DIRECTOR NAME <b>JOHN M. WEBER &amp; SONS INC.</b> ADDRESS <b>401 S. CHESTER ST.</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4, if not already attached, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It should be removed from the certificate. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 06381

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		3 1 87		630 PM	
Laura Grace Slagle					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR	73 YRS	IF UNDER 24 HRS	
		6 4 13			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Baltimore Co., MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Towson	Saint Joseph Hospital		Homemaker		Homemaker
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
MARYLAND		BALTIMORE	21234	YES NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS, / ZIP CODE	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		1711-AT EDGEWOOD RD. 21234	
JOSEPH T. WILLINGER, SR.		HAZEL H. HOWARD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		218-09-7593		GEORGE S. SLAGLE BALTIMORE, MD 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)					Immediate
DUE TO, OR AS A CONSEQUENCE OF (b)					7 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
N/A		N/A		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR		N/A	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		N/A		STREET CITY OR TOWN COUNTY STATE	
				N/A	
22a. I certify that (I) (this hospital) attended the deceased from 3/22, 19 87, to 3/1, 19 87, that (I) (we) lost the deceased alive on 3/1, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Duane Smoot MD				3/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Duane Smoot		7620 York Road, Towson, Md 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		MARCH 5, '87		OAK LAWN CEMETERY	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. CITY OR TOWN	
NAME		COUNTY		STATE	
WILLIAM E. JOHNSON		BALTIMORE CO., MD			
ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
8521 LOCH RAVEN BLVD.		MAR 02 1987		James Johnson	

BP



048516 MAR 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please send the top 3 pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

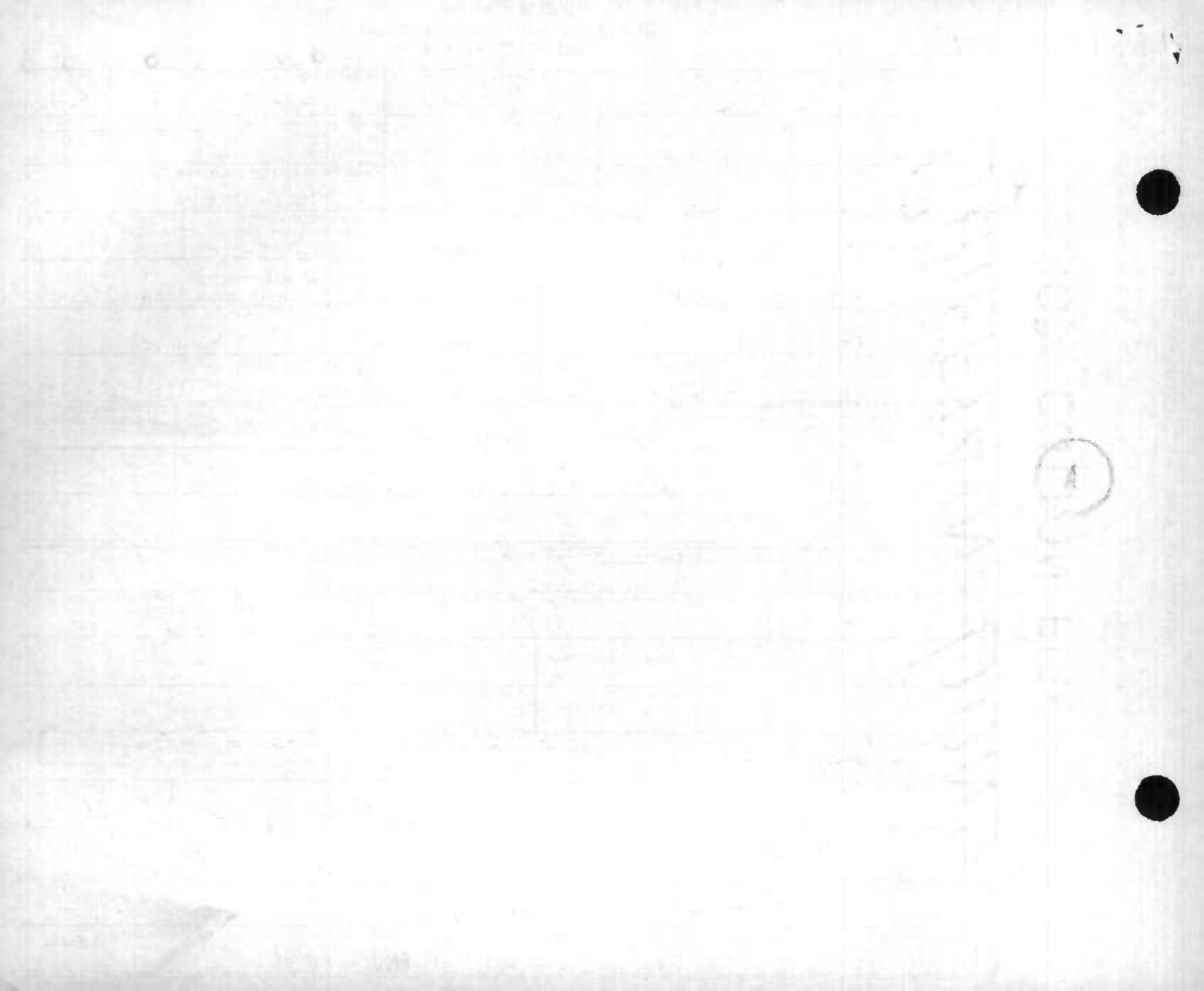
IMPORTANT: If item 21 is marked "other" it shows any injury, or other trauma, event, the medical examiner may be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 06888

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Josephine M Slaughter</i>			2a DATE OF DEATH MONTH DAY YEAR <i>3-26-87</i>		2b HOUR <i>1650 P.M.</i>	
4 SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>August 22, 1906</i>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS.		
10 CITY OR TOWN OF DEATH <i>Randallstown</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore County General Hospital</i>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i>			13b COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Catonsville</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Frank Perticone</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Josephine Santora</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>218-09-3593</i>		17 INFORMANT'S NAME AND ADDRESS <i>Mr. Kenneth Slaughter</i> <i>6129 Wheatland Road Catonsville, MD. 21228</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Decubitus ulcers</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <i>3-23-87</i> , 19 <i>87</i> , to <i>3-26-87</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>3-27-87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <i>Singh</i>				22c DATE SIGNED <i>3-26-87</i>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>KARAT GIRGIS</i>				22e ADDRESS <i>Baltimore County Hosp</i>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>3/28/87</i>		23c NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		
24 FUNERAL DIRECTOR'S NAME <i>Loring Byers Funeral Directors, Inc.</i>		24b ADDRESS <i>8728 Liberty Road Randallstown, MD. 21133</i>		25a DATE REC'D. BY REGISTRAR <i>MAR 27 1987</i>		
25b REGISTRAR'S SIGNATURE <i>Julia Deaton</i>						



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please note: Coroner's papers, Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 REG. NO. 06889		9 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert W. Smith		10a. DATE OF DEATH MONTH DAY YEAR 3-27-87		10b. HOUR 1255p M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 27 1906		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	
7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Mgr		12b. KIND OF BUSINESS OR INDUSTRY Food	
10 CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County Gen Hospital		12c. STREET ADDRESS, ZIP CODE 3838 Roland Ave 21211		13a. STATE Md		13b. COUNTY Baltimore	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 3838 Roland Ave 21211		14. FATHER'S NAME FIRST MIDDLE LAST Ernest A. Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary J. Wherly	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 212 07 0794		17 INFORMANT Kathryn P Smith		ADDRESS Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Chronic Renal Failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-19-87</u> to <u>3-27-87</u> , that (I) (we) saw the deceased alive on <u>3-27-87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>R. Girgis</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-27-87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RABEAT Y. GIRGIS</u>		22e. ADDRESS <u>Baltimore County Hosp.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/30 1987		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemt		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto Md			
24 FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home				ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR APR - 1 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return both pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO.

06890

1. DECEASED NAME (TYPE OR PRINT) <b>Doris B. Smith</b>			2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>3 2 87 3:55 PM</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 25, 1918</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Towson, Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris hospice</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles I. Breidenbaugh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie R. Reynolds</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-07-5688</b>	17. INFORMANT ADDRESS <b>385 W. Brown St.</b> <b>Mr. Kurt Smith, Birmingham, Michigan, 48009</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Rheumatoid Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> , 19 <b>83</b> , to <b>3/2</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>3/2</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Eddie Nakhudg</b>				22c. DATE SIGNED <b>3/2/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eddie Nakhudg</b>				22e. ADDRESS <b>Dulaney Valley Rd. Towson, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-6-1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fork U. Meth. Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fork Baltimore Md.</b>
24. FUNERAL DIRECTOR NAME <b>E. F. LASSAHN, 11750 BELAIR RD</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 05 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

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CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove certain papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial. (If the death is a homicide, or other traumatic event, the medical examiner must be notified.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy V. SMITH</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 15, 1987</b>		2b. HOUR <b>1:15 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 28, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Fort Howard</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8902 Avenue B 21219</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence B. Cook</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Verna M. Truete</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-38-5933</b>		17. INFORMANT ADDRESS <b>Evelyn S. Lau PO Box 123 Key Colony Beach, FL</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory Failure</b> (c) <b>Metastatic Breast Cancer</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <b>March 14</b> , 19 <b>87</b> , to <b>March 15</b> , 19 <b>87</b> , that (a) (we) last saw the deceased alive on <b>March 15</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (c) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Douglas Lawler, M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3/15/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Douglas R. Lawler MD</b>				22e. ADDRESS <b>9000 Franklin Square Drive</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-18-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk</b>				24b. ADDRESS <b>7922 Wise Ave. Dundalk, MD 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia T. ...</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the local certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please give me, embossed papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06892	
1. DECEASED NAME (TYPE OR PRINT) FIRST FLORENCE MIDDLE CLAYTON LAST SMITH <i>FLORENCE SMITH</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 6 87</i>		2b. HOUR <i>0205 M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>July 8, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>88</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>England</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Balto. County Gen. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Child Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>849 Wellington St. 21211</i>	
14. FATHER'S NAME FIRST George MIDDLE LAST Clayton		15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE Isabell LAST Duffell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>219-10-4885</i>		17. INFORMANT ADDRESS <i>10729 Park Heights Ave. 21117 Records Baptist Home of Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Post Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septisemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <i>it</i> (this hospital) attended the deceased from <i>02/19</i> , 19 <i>87</i> , to <i>3/6</i> , 19 <i>87</i> , that <i>it</i> (we) last saw the deceased alive on <i>3/6</i> , 19 <i>87</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>it</i> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Young J. R. MD</i>		DEGREE		22c. DATE SIGNED <i>3/6/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Young J. R. MD</i>		22e. ADDRESS <i>B. C. G. H.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-9-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Parkville Baltimore Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Mitchell-Wiedefeld Home</i>		ADDRESS <i>6500 York Road 21212</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 10 1987</i>	
		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rudner</i>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 0 6 8 9 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Frances W. SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 21, 1987</b>			2b. HOUR <b>12:35am</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 30, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machine Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Western Elect</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stella</b>			13e. STREET ADDRESS / ZIP CODE <b>528 S. 45th Street 21224</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-10-7592</b>		17. INFORMANT ADDRESS <b>Leonard J. Bowling 1807 Putty Hill Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Congestive Heart Failure Chronic Obstructive Pulmonary Disease</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from <b>March 11, 1987</b> to <b>March 21, 1987</b> , that (we) last saw the deceased alive on <b>March 21, 1987</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (and we) view the body after death.									
22b. SIGNATURE <i>Anil Minocha</i>					DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3/21/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Anil Minocha, M.D.</b>					22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-24-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk</b> ADDRESS <b>7922 Wise Ave. Dundalk, MD 21222</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all non-paper pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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047903 MAR 23 1987

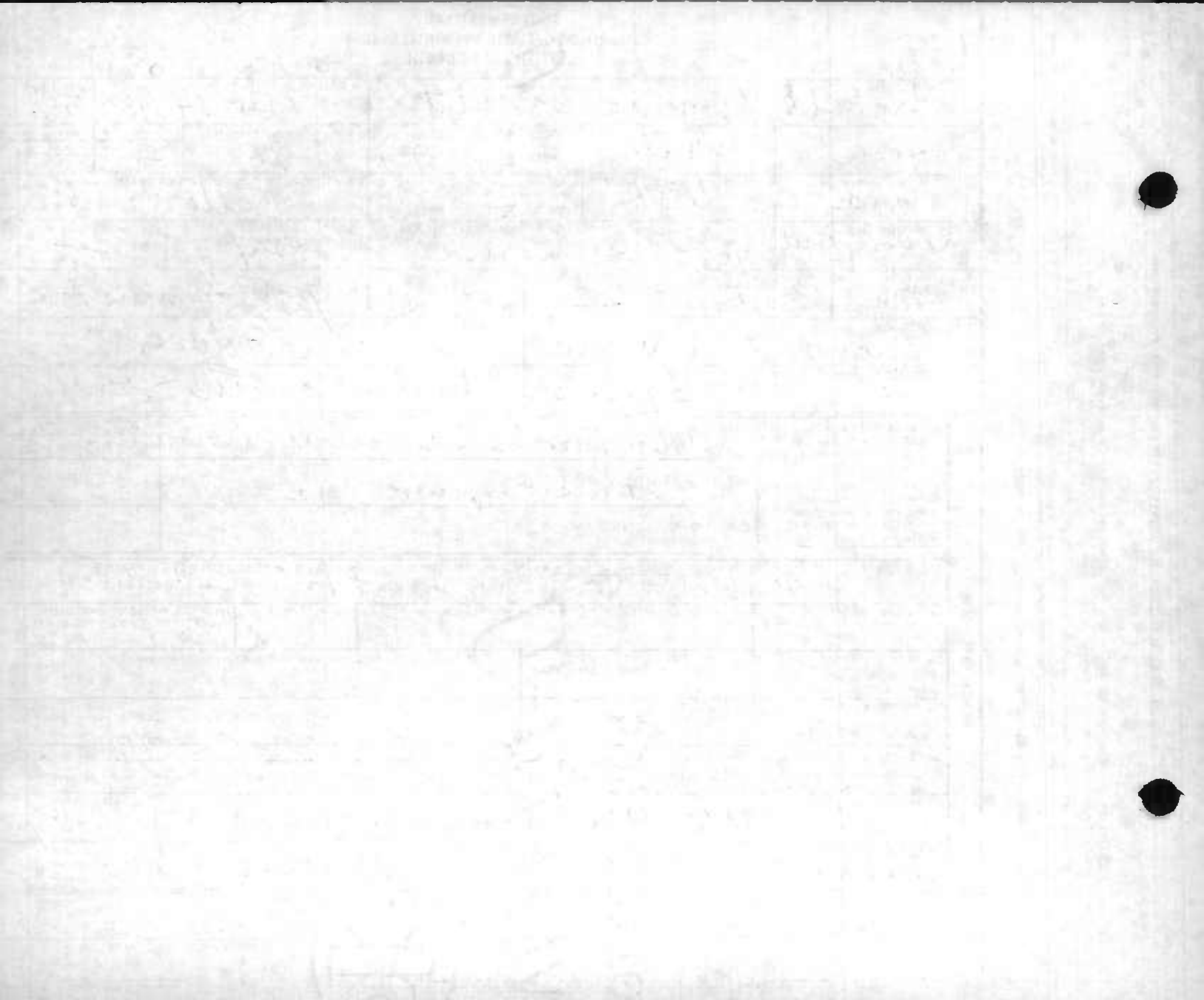
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06844	
1. DECEASED NAME (TYPE OR PRINT) Isabel Virginia Smith			2a. DATE OF DEATH MONTH DAY YEAR Mar 14 1987		2b. HOUR 5 A M
3. SEX Fem	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan 15 1909	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Perry Hall		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9035 Simms Ave		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md		13b. COUNTY Baltimore	13c. CITY OR TOWN Perry Hall	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Eugene B. Morgan		15. MOTHER'S MAIDEN NAME Alice G. Rover		16. ADDRESS Charles Smith - Son.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-28-7276		17. INFORMANT Charles Smith - Son.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease Arrhythmia 9019 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DOE TO, OR AS A CONSEQUENCE OF (b) Stress - exposure Cold DOE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Previous Congestive heart failure - Senile Confusion					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 87, to Mar 87, that (I) (we) saw the deceased alive on Jan 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE Frank T. Kasik Jr.		DEGREE M.D.		22c. DATE SIGNED 3/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK T. KASIK JR. M.D.		22e. ADDRESS 9005 HARFORD ROAD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-16-1987		23c. NAME OF CEMETERY OR CREMATORY PERRY HALL METH.	
23d. LOCATION CITY OR TOWN COUNTY STATE Perry Hall BALTO. MD.		24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES ROAD		25a. DATE REC'D. BY REGISTRAR MAR 20 1987	
25b. REGISTRAR'S SIGNATURE Richard A. Anderson					



048333 MAR 27 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6895

1. DECEASED NAME (TYPE OR PRINT)		FIRST Ruth		MIDDLE L.		LAST Smith		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH 3		DAY 23		YEAR 1987		2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 26, 1898		6. AGE (IN YEARS) (AT BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 3		DAY 23		YEAR 1987		2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Staunton, Va.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home-Fusting Av.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife - Homemaker				12b. KIND OF BUSINESS OR INDUSTRY									
12a. STATE Md.		12b. COUNTY Baltimore		12c. CITY OR TOWN Catonsville		12d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12e. STREET ADDRESS 21228 14 S. Beechwood Avenue													
14. FATHER'S NAME FIRST MIDDLE LAST Marry Myers Lewis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Elizabeth Fifer				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ----													
16b. SOCIAL SECURITY NO. 213-54-3782				17. INFORMANT 210 S. Rolling Road- Md. Mrs. Doris F. Stubbs-Catonsville,																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure and Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21228.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												DATE SIGNED 3-24-87					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/25/87				23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland									
24. FUNERAL DIRECTORY NAME ADDRESS Sterling Funeral Estate, P.A. 736 Edmondson Ave.; Catonsville, Md. 21228.				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove the carbon copy of Page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06896	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Shirley Smith</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>March 17, 1987</b>			2b. HOUR <b>M</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 16, 1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>55</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Arbutus/ Baltimore County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Arbutus</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5208 Benson Avenue 21227</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Register nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Aliquippa Hospital</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5208 Benson Avenue 21227</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles W. Shaffer</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Figley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>166-26-6240</b>		17. INFORMANT ADDRESS <b>Mrs. Cynthia Hixon 5208 Benson Avenue Baltimore, MD. 21227</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic + Brain Metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Small cell lung cancer</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>2 mo.</b> <b>1 yr</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/4</b> , 19 <b>86</b> , to <b>3/17</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>1/15</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. William Waterfield</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/17/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. William Waterfield</b>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3/20/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>John Anderson Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Raccoon Township, Aliquippa PA</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
8728 Liberty Road Randallstown, MD. 21133											

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DIVISION OF VITAL RECORDS, 2D1 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06897	
1. DECEASED NAME (TYPE OR PRINT) Mildred E. Sommer					2a. DATE OF DEATH MONTH DAY YEAR March 18, 1987					2b. HOUR 8:15 p.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 21 1905			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, Maryland MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 300 W. Seminary Ave. 21093			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Radwitch					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Connolly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-7276		17. INFORMANT ADDRESS Joanne Thompson 17 Gunhurst Garth 21236							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) <u>Cerebral vascular accident</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> , 19 <u>87</u> , to <u>March 18, 1987</u> , that (I) (we) last saw the deceased alive above <u>March 18, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-19-87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. David Nagel, M.D.						22e. ADDRESS 1205 York Road Baltimore MD 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 03/21/1987		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR MAR 19 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper (Page 1 and 2) should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		Film 6526 Item #1, 15		8 7 REG. NO. 0 6 8 9 8							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
MILTON		A.		SORRELL, Jr.				3 30 87		8:25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M		W		7 10 27		59		MONTHS DAYS		HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md		U. S. A.				COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
IDWSON		ST. JOSEPH HOSPITAL		INSURANCE CONSULTANT							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		HARFORD		BEL AIR		YES <input type="checkbox"/> NO <input type="checkbox"/>		704 W. MACPHAIL RD.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Milton A. Sorrell Sr		Helen Webber		YES		216-24-4003		Albina Sorrell		704 W. MacPhail Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										MINUTES	
IMMEDIATE CAUSE (a) POSSIBLE CARDIAC ARRYTHMIA											
DUE TO, OR AS A CONSEQUENCE OF											
(b) CORONARY ARTERY INSUFFICIENCY											
DUE TO, OR AS A CONSEQUENCE OF											
(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SUBTRACHEAL CYST COMPRESSING ATRIA OF HEART											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
REYNALDO ORTUELA-GOMEZ, M.D.								3-31-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
22f. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation						4.1.87		Westview Cem		Baltimore Co., Md	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Raymond L. Kucrowski 2525 1st St 21234						APR - 2 1987		James Davidson-Randall			

7/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove "Support" Pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 / 0 6 8 9 9 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louis Frank <del>Frank</del> SOUL Jr				March 16, 1987				2:41a M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 8 1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION [IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS] Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Beth. Steel			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 804 Mace Ave. 21221			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Soul Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-1154		17. INFORMANT ADDRESS David Soul 312 West Timonium Road 21093							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest with Anoxic Encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Septicemia Positive Blood cultures for Staph</u> DUE TO, OR AS A CONSEQUENCE OF <u>with metabolic acidosis</u> (c) <u>Probable Superior Vena Cava Syndrome</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 8</u> , 19 <u>87</u> , to <u>March 16</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 16</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <u>Alfonso Ruiz</u> M.D.				DEGREE				22c. DATE SIGNED 3-16-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Alfonso Ruiz</u> M.D.				22e. ADDRESS 9000 Franklin Square Dr., 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/19/87		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial				23d. LOCATION CITY OR TOWN Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Connelly Funeral Home						ADDRESS 300 Mace Ave. 21221		25a. DATE REC'D. BY REGISTRAR MAR 17 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u>	

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. CONTINUE WITH ITEMS 19, 20, 21, AND 22 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6900

1. DECEASED NAME (TYPE OR PRINT) <b>John M. SPAHN</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>March 19 1987</b>			2b. HOUR <b>10 PM</b>		
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 30 1900</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>86 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>March 19 1987</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS Hospice</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMP.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HAIR</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>2300 DULANSY VALLEY RD. 21093</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB SPAHN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE ULUBER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>16-019042</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Fracture of Right Hip</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCLD</b>								APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE <b>32 days</b> <b>Wks</b> <b>35 yrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION <b>2/10/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fractured Right Hip</b>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>2-6-1987</b>		21c. HOW INJURY OCCURRED (ENTER NAME OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell in</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Hospice</b>		21f. LOCATION CITY OR TOWN <b>BT Springs</b> COUNTY <b>Timonium</b> STATE <b>BALTIMORE</b>				
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Charles F. O'Connell</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>3/14/87</b>
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-18-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANSY VALLEY</b>		23d. LOCATION CITY OR TOWN <b>Timonium</b> COUNTY <b>BALTIMORE</b> STATE <b>MD.</b>		
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPEL OF CHIMES</b> ADDRESS <b>2325 YORK ROAD</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



*[Faint handwritten text at the bottom of the page, possibly a date or signature.]*

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, which should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified and signed.

IMPORTANT:

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06901

FOR 1 - STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 06901																																							
1. DECEASED NAME (TYPE OR PRINT) Mary Ellen Speake										2a. DATE OF DEATH MONTH DAY YEAR March 23 1987										2b. HOUR 8:15 AM																																							
3. SEX Female										4. RACE Caucasian										5. DATE OF BIRTH MONTH DAY YEAR October 4 1887										6. AGE (IN YEARS (LAST BIRTHDAY)) 99 YRS										7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.										8. IF UNDER 21 HRS HOURS MIN.									
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland										10. CITIZEN OF WHAT COUNTRY? U.S.A.										11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.										13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.																			
14. CITY OR TOWN OF DEATH Baltimore										15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perring Parkway Nursing Home										16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress										17. KIND OF BUSINESS OR INDUSTRY Hochschild Kohn																													
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY Baltimore										13c. CITY OR TOWN Pikesville										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS / ZIP CODE 9A Sage Court 21208																			
14. FATHER'S NAME FIRST MIDDLE LAST George Washington										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanette Olivia Walker										16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No										17. SOCIAL SECURITY NO. 217-03-4919										18. INFORMATION Mr. Roy N. Palmer 4618 Deblen Cir. Apt. D Pikesville Maryland																			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> 19 <u>87</u> , to <u>3/26</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/22</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (our) (ours) the body after death.										22b. SIGNATURE <u>[Signature]</u> DEGREE										22c. DATE SIGNED <u>3/23/87</u>																																							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. Bossert</u>										22e. ADDRESS <u>5215 Springdale Way Broomfield</u>																																																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 3/26/87										23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel Maryland																													
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133										25a. DATE REC'D. BY REGISTRAR MAR 24 1987										25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>																																							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

8 REG. NO. 06923  
2a DATE OF DEATH MONTH DAY YEAR 3 30 87 2b HOUR 6:10 PM

1. DECEASED NAME FIRST MIDDLE LAST  
Dinah Spritz

3. SEX FEMALE 4. RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR 9 15 92 6. AGE (IN YEARS LAST BIRTHDAY) 94 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.

10. CITY OR TOWN OF DEATH PIKESVILLE 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE 12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND 13c. COUNTY BALTO. 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE APT. 1011 2500 W. BELVEDERE AVE. (21215)

14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN UNKNOWN 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 262-78-9520 17. INFORMANT ADDRESS SIGMUND SPRITZ 2506 PINEBRUSH RD. (21209)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cardiac Arrest  
DUE TO, OR AS A CONSEQUENCE OF (b) NACVD  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Diabetes Mellitus

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
Sudden  
years  
10 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/11, 1987, to 3/30, 1987, that (I) (we) last saw the deceased alive on 3/27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE 22c. DATE SIGNED 3/31/87  
Joseph C. Matchar MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH C. MATCHAR 22e. ADDRESS 3635 Old Court Rd

23a. BURIAL, CREMATION, REMOVAL BURIAL 23b. DATE 4/2/87 23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MENS CEM 23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN, BALTO., MD.

24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) 25a. APR 3 1987 25b. REGISTRAR'S SIGNATURE Gordon R. Rader

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, show any injury, or other traumatic event, the medical examiner may be notified of one.

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**RETURN TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES.

**RETURN TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. EUSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 06904	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Helen		A.		Stankis			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
Female		White		8 15 1900		86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Baltimore County	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Reisterstown		314 W. Cherry Hill Rd. 21136		Retired-Balt. City Schools			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Baltimore		Reisterstown		314 W. Cherry Hill Rd. 21136	
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME	
Unknown						Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		217-16-5603		Barbara A. Harden		204 Delight Rd. Reisterstown, Md. 21136	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				A-J-K			
				DUE TO, OR AS A CONSEQUENCE OF			
				(b)			
				DUE TO, OR AS A CONSEQUENCE OF			
				(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		TITLE (SPECIFY)		DATE SIGNED		3/7/87	
ACTUAL SIGNATURE Stanley Z. Feljenberg MD.		M.D. Dr. Feljenberg		MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		11 E. Chase St. 21202			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3-12-87		Evergreen Mem. Gardens		Finksburg Carroll Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Eline Funeral Home		Reisterstown, Md.		MAR 12 1987		A. J. Golden	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		87		REG. NO. 06905					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE L. STANLEY				2a. DATE OF DEATH MONTH DAY YEAR March 2, 1987			2b. HOUR 3:46 a.m.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 02 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8b. CITIZEN OF WHAT COUNTRY? USA		8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Gildenfenny				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Creswell		13e. STREET ADDRESS / ZIP CODE 32 Northwood Dr. 21093			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS June Larkins 32 Northwood Dr. 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic coronary vascular heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Fibrous pericarditis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> , 19 <u>87</u> , to <u>3/2</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert A. Palermo</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Palermo, M.D.				22e. ADDRESS 6701 N. Charles St. Baltimore MD 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/5/87		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr., 3818 Roland Ave. 21211				25a. DATE REC'D. BY REGISTRAR MAR 04 1987		25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>			

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06906

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Bertha						Stanton		3		21		87				8:25 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Female		Caucasian		2 MONTH 20 DAY 07 YEAR		80 YRS		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Baltimore, Md.		USA				Towson, Maryland		Balto. Co.		MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Dulaney Valley		Stella Maris Hospice		Housewife.													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
Maryland		Baltimore		Perry Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4226 Silver Spring Rd., 21128									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST		FIRST MIDDLE LAST															
Vincent Praydis		Korolna Krawcyk															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (son)		ADDRESS											
NO		NO		213-09-9899		Anthony Wesclowski		Silver Spring Rd.		Perry Hall, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Bowel Obstruction DUE TO, OR AS A CONSEQUENCE OF (b) Past Bowel Obstruction-Corrected by Surgery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of breast and bladder; Parkinson's Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
Carla A. Alexander		MD															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Dr. Carla Alexander M.D.		2300 Dulaney Valley Road															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		3-23-87		New Cathedral		Baltimore, Maryland											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Ruck Towson Funeral Home, Inc.		1050 York Rd.		MAR 26 1987													

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Medical examiner must be notified by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

*[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 REG. NO. 06907					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET Anna Starr</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3/14/87</b>				2b. HOUR MIN. <b>5<sup>30</sup> A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 6 '09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN VALLEY Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Perry Hall</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4804 Variation Road 21236</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Cummins</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Smith</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-14-6949</b>		17. INFORMANT ADDRESS <b>Joan Chavis 4804 Variation Rd. 21236</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Vascular disease</b> Years DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3</b> 19 <b>85</b> , to <b>31</b> 19 <b>87</b> that (I) (we) last saw the deceased alive on <b>2</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/16/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Minicov</b>				22e. ADDRESS <b>11 E. Chestnut Hill La. Pikesville</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-17-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Eastwood, Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Charles S. Zeiler &amp; Son Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 17 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

W



EXHIBIT 1

X

3/10/12  
The Court will be  
final  
5-7-12



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JERRY JAMES STEPAN					2a. DATE OF DEATH MONTH DAY YEAR MARCH 6, 1987			2b. HOUR 8:55 P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 08 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A.M.C., FORT HOWARD, MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DENTIST		12b. KIND OF BUSINESS OR INDUSTRY HEALTH	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Wenceslaus Stepan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Rezack					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 11		17. INFORMATION ADDRESS CLINICAL RECORD, VAMC, FORT HOWARD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>GENERALIZED CANCER</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 5 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 9</u> , 19 <u>87</u> , to <u>MARCH 6</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Waclaw Kazimierzczak</i>				DEGREE M.D.				22c. DATE SIGNED MARCH 7, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WACLAW KAZIMIERCZAK, M.D.				22e. ADDRESS V.A.M.C., FORT HOWARD, MARYLAND 21052					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 03/09/87		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD.			
24. FUNERAL DIRECTOR NAME <i>Jeffrey</i>				ADDRESS 1211 Chesapeake Ave. 21237		25a. DATE REC'D. BY REGISTRAR MAR 09 1987		25b. REGISTRAR'S SIGNATURE <i>Julia</i>	

LIBRARY

104

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Nesbeth F. Stevenson</b>					2a. DATE OF DEATH MONTH <b>3</b> DAY <b>29</b> YEAR <b>87</b>		2b. HOUR <b>2:06 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>09</b> YEAR <b>18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7c. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tailor</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>					13b. CITY OR TOWN <b>Baltimore</b>		13c. STREET ADDRESS / ZIP CODE <b>6308 Old Harford Rd. 21214</b>		
14. FATHER'S NAME FIRST <b>Earl</b> MIDDLE <b></b> LAST <b>Caricofe</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Ollie</b> MIDDLE <b></b> LAST <b>McNeal</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217-09-5638</b>		17. INFORMANT ADDRESS <b>Mr. Robert W. Stevenson Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>506 120 1st Pierre Dr.</b>		CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Maryland</b>	
22a. I certify that (1) (this hospital) attended the deceased from <b>Mar 18 87</b> to <b>Mar 29 87</b> , that (1) (we) lost <b>above (1) (we) (did) (did not) view the body after death</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <b>Robert E. Stoner</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>Mar 29 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert E. Stoner</b>				22e. ADDRESS <b>506 120 1st Pierre Dr.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 1, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP



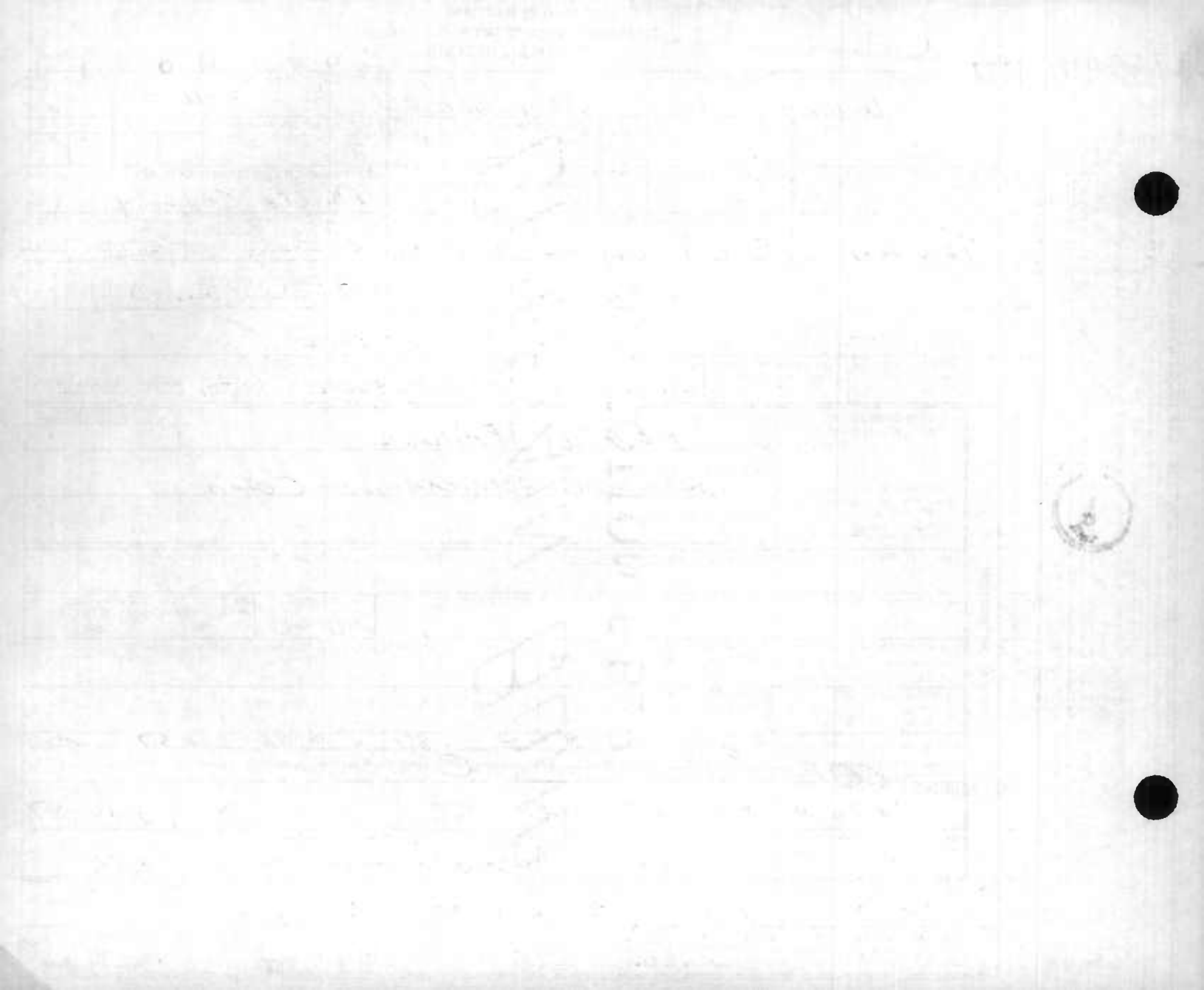
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in envelope with carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William C. STEVENSON</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>3-16-87</i>		2b. HOUR <i>10</i> AM		
3. SEX <i>Male</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9/17/15</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>STELLA MARIS HOSPICE</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Supervisor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Western Elec.</i>	
13a. STATE <i>MD.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3692 Galloway Rd., 21220</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Stevenson</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sadie Coulbourne</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>217-07-4739</i>		17. INFORMANT ADDRESS <i>Virginia H. Stevenson (wife) same address</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEPATIC FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>METASTATIC ADENOCARCINOMA COLON</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>3-13</i> , 19 <i>87</i> , to <i>3-16</i> , 19 <i>87</i> , that (I/we) last saw the deceased alive on <i>3-16</i> , 19 <i>87</i> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death.									
22b. SIGNATURE <i>Carla S. Alexander, MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>3-16-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Carla S. Alexander, M.D.</i>				22e. ADDRESS <i>Stella Maris Dulaney Valley Rd. - Towson, MD 21204</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/19/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto., MD.</i>			
24. FUNERAL HOME <i>Genmunk Funeral Home, Inc., 9705 Belair Road, Balto., Md. 21236</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 17 1987</i>		25b. REGISTRAR'S SIGNATURE <i>L. E. Finkbeiner</i>			

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the medical examiner, it should be filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06911	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Koma Zawa (Desambourg) Stinchcomb				2a. DATE OF DEATH MONTH DAY YEAR March 18, 1987	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 6, 1904	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
10. CITY OR TOWN OF DEATH Catonsville		7c. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summit Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN N. Linthicum		13c. STREET ADDRESS / ZIP CODE 29 Patapasco Road 21090	
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Desambourg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Golda Lee Bransford		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Educator	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214.40.4526		17. INFORMANT (son) ADDRESS William C. Stinchcomb 637 Alston Place Severna Park, Md. 21146	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>adenocarcinoma colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: <u>2 1/2 yrs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-26</u> , 19 <u>87</u> , to <u>3-18</u> , 19 <u>87</u> , that (I) (we) lost <u>saw the deceased alive on 3-17</u> , 19 <u>87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>I</u> (we) (did) <u>not</u> view the body after death.					
22b. SIGNATURE <u>Laurence R. Gallagher M.D.</u>				22c. DATE SIGNED 3-19-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. R. L. Gallagher, M.D.				22e. ADDRESS 3455 Wilkins Ave, Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 20, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN Brooklyn Park		23e. COUNTY A A Co.		23f. STATE Md.	
24. FUNERAL DIRECTOR NAME <u>R. George Hopkins</u> Singleton Funeral Home Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 19 1987	
25b. REGISTRAR'S SIGNATURE <u>R. George Hopkins</u>					



20% COTTON-FIBER

MADE IN U.S.A.

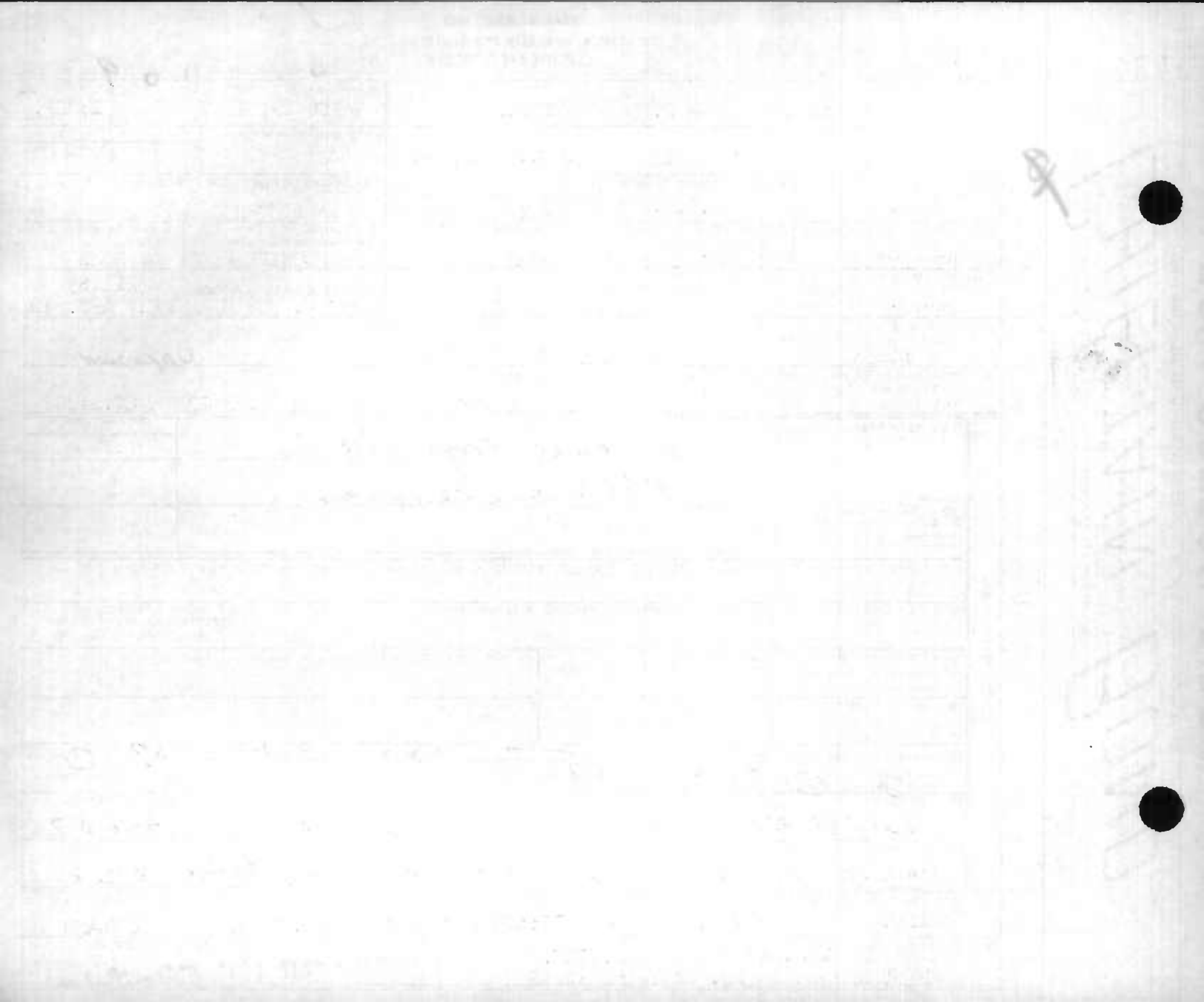
WASH & DRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		7b. HOUR	
MARIE S. STOLBERG						MARCH 15, 1987		2:05P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE		CAUCASIAN		AUGUST 13, 1884		102		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
RUSSIA		U.S.A.				BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PIKESVILLE		PIKESVILLE NURSING HOME				HOUSEWIFE		AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					13e. STREET ADDRESS / ZIP CODE (21215)				
MARYLAND BALTIMORE					3912 W. NORTHERN PKWY, APT. 1D				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
EUGENE STOLBERG					FANNIE UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					218-14-5078		ERNEST STOLBERG 902 BARE BRANCH CT. 21208		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>83</u> to <u>3-15</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3-13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
<u>Harold B. BOB MD</u>								3-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Harold B. BOB MD					7220 Park Heights Ave 21208				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			3/17/87		BETH TFILOH CEMETERY		BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215					MAR 24 1987		<u>Sol Levinson</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please forward page 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		M	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		3. SEX		4. RACE		5. DATE OF BIRTH	
Joanna		I. Stominski		Female		White		6. AGE (IN YEARS LAST BIRTHDAY)	
						79		7. IF UNDER 1 YEAR	
								MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Baltimore city		MD.	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		13. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		14. KIND OF BUSINESS OR INDUSTRY		15. C&P Telephone	
Baltimore		6225 Walker Mews Apt. N 113		Ref. operator					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. INSIDE CITY LIMITS?		18. STREET ADDRESS / ZIP CODE		19. Balto. Md.		20. 6225 Walker Mews Apt. N 113	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN					
Maryland		BALTO		Baltimore					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		no		217-07-8694		Mrs. Joan Arnold 1174 Pelham Wood Rd. 21234	
Bernard		Mullin							
Elizabeth		McAuliffe							
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		20. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		21. DUE TO, OR AS A CONSEQUENCE OF		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		23. 2 min	
		Respiratory arrest		(b) End stage emphysema				20 yrs.	
				(c) TB & Thromboplasty				30 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		recent pneumonia (R.I.)							
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY?		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
31. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		32. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
34. I certify that (I) (this hospital) attended the deceased from		Feb 19 87		to Feb 19 87		that (I) (we) lost		saw the deceased alive on Feb 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
35. SIGNATURE		DEGREE		36. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		37. DATE SIGNED		3/18/87	
38. PHYSICIAN'S NAME (TYPE OR PRINT)		39. ADDRESS							
McDougal		GOOD Stm.							
40. BURIAL, CREMATION, REMOVAL (SPECIFY)		41. DATE		42. NAME OF CEMETERY OR CREMATORY		43. LOCATION CITY OR TOWN		COUNTY STATE	
Burial		3/20/87		Dulaney Valley		Timonium		Balto. Md.	
44. FUNERAL DIRECTOR NAME		45. ADDRESS		46. DATE REC'D. BY REGISTRAR		47. REGISTRAR'S SIGNATURE			
Mitchell-Wiedefeld		6500 York Rd. 21212		MAR 18 1987					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please initiate the necessary arrangements with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Katherine STORRER					2a. DATE OF DEATH MONTH DAY YEAR March 19, 1987			2b. HOUR 11:05pm		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czech.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST unknown Janik					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 217-22-1585		17. INFORMANT ADDRESS John W. Storrer Sr. (son) Rd., Joppa Md. 21085					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest; Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Coronary Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19</u> , 19 <u>87</u> , to <u>March 19</u> , 19 <u>87</u> , that (X) (we) last saw the deceased alive on <u>March 19</u> , 19 <u>87</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>J. Loh, M.D.</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 3-19-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Loh, M.D.					22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/23/87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR'S NAME Schmidke Funeral Home, Inc. 9705 Belair Rd., Balto. Md. 21236					25a. DATE REC'D. BY REGISTRAR MAR 24 1987		25b. REGISTRAR'S SIGNATURE <u>John W. Storrer Sr.</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and submit them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>James Gordon Stubbs</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 8, 1987</b>			2b. HOUR <b>8:34 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-24-1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8313 Nunley Drive Apt. A</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8313 Nunley Dr. Apt A 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Morton Stubbs</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Seifert</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT ADDRESS <b>Loretta B. Stubbs, Same as 13e</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Possible Massive CVB.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCA.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-21</b> , 19 <b>86</b> , to <b>3</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>12-21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Donato A. Vargas Jr.</i>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donato A. Vargas Jr. MD</b>				22e. ADDRESS <b>4706 Harford Rd. Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-12-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Ruck</i>			

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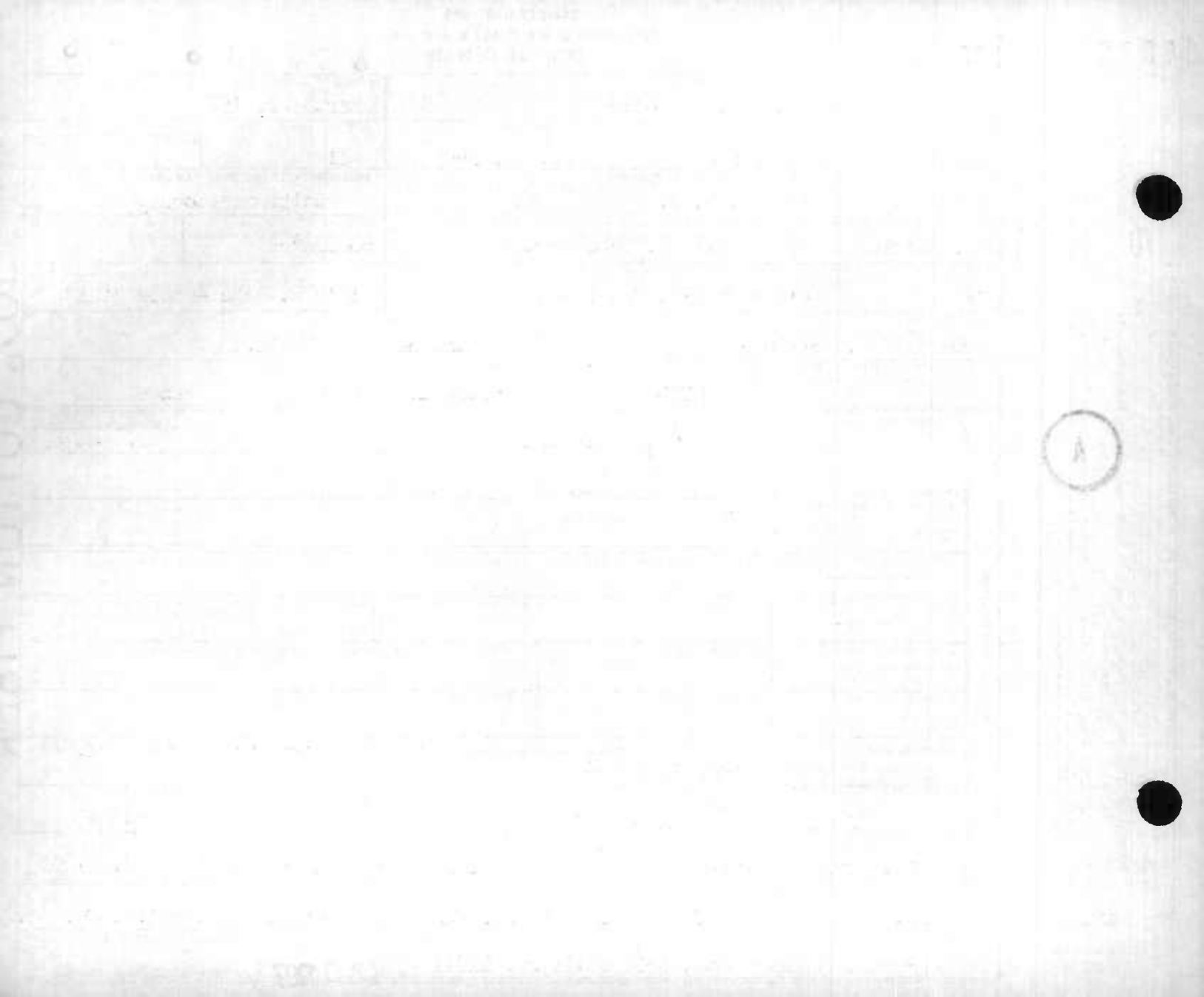
048953 APR -

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2a should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "yes", item 21a shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Carrie B. Stuller</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 27, 1987</b>			2b. HOUR M <b>AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 26, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Mt. Washington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1218 W. Lake Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Mt. Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1218 W. Lake Avenue 21210</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard H. Staines</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche Halbert</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220 14 9261</b>		17. INFORMANT <b>Harriet L. Wilhelm</b>			ADDRESS <b>same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hyperkalemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sev. months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1983</u> to <u>Mar 27</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Mar 14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Bruce Rosenberg MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Bruce Rosenberg</b>				22e. ADDRESS <b>1134 York Road Lutherville, Md. 21093</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>03/27/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>May's Chapel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Burgee-Henss Funeral Home, 3631 Falls Rd. 21211</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>		25b. REGISTRAR'S SIGNATURE <u>James Davidson</u>			



048233 MAR 23 1987

17 FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06917  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Sister Mary Louise Sullivan V.H.M.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 21 87</i>			2b. HOUR <i>8:40 AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>October 9, 1894</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>YRS.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Massachusetts</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> County MD			
10. CITY OR TOWN OF DEATH <i>Towson Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Stella Maris</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Religious</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Towson</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <i>2300 Dulaney Valley Rd. 21204</i>			14. FATHER'S NAME FIRST MIDDLE LAST <i>Horace Tessier</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Brigid Gallagher</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>090-05-3474</i>		17. INFORMANT <i>Pat Harbin</i>		ADDRESS <i>Stella Maris</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOVASCULAR Accident.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>URINARY Tract Infection</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>8/1/86</i> , 19____, to <i>3/21</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>3/20</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Carla A. Alexander MD</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/21/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR CARLA A ALEXANDER MD</i>						22e. ADDRESS <i>2300 DULANEY VALLEY RD STELLA MARIS HOSPICE</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>3/24/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City, Maryland</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</i>						25a. DATE REC'D. BY REGISTRAR <i>MAR 23 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia Harbin</i>	

MEDICAL CERTIFICATION

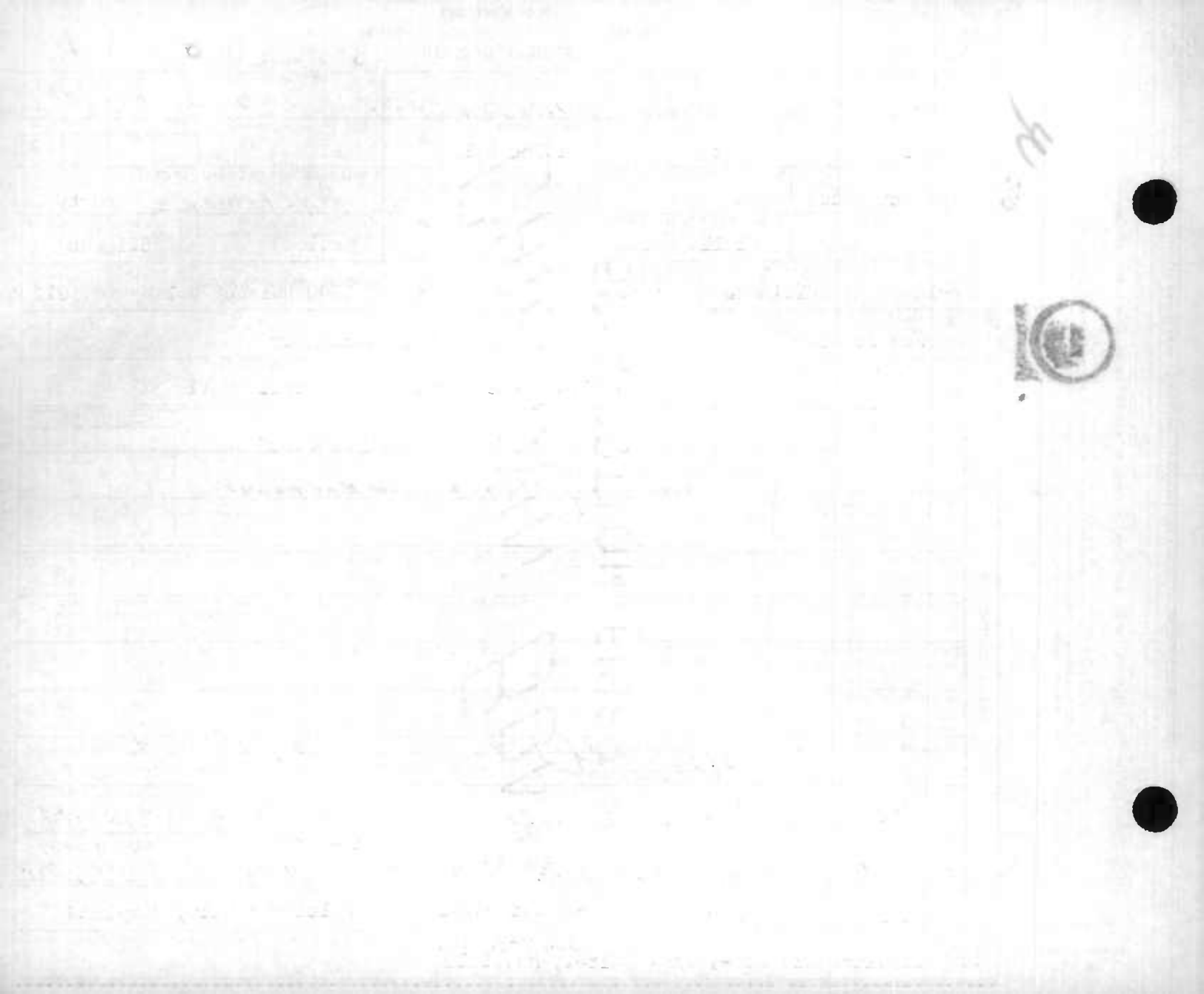
99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain in carbon of Part 1 and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Margaret SURGUY					2a. DATE OF DEATH MONTH DAY YEAR March 7, 1987			2b. HOUR 10:25 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 12 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE CITY OR TOWN Md. Balto. Middle River					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7323 Gunpowder Road 21220		
14. FATHER'S NAME FIRST MIDDLE LAST George Suehs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Stenger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-14-2589		17. INFORMANT ADDRESS Marjorie Martins 7330 Gunpowder Rd. 21220			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } Small Cell Cancer									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (i) (this hospital) attended the deceased from March 1, 1987, to March 7, 1987, that (i) (we) last saw the deceased alive on March 7, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE Julio Ruiz M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/7/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julio Ruiz M.D.					22e. ADDRESS 9000 Franklin Square Drive				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/11/87		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland			
24. FUNERAL DIRECTOR NAME Connelly Funeral Home 300 Mace Ave. 21221					25a. DATE REC'D. BY REGISTRAR MAR 10 1987		25b. REGISTRAR'S SIGNATURE		

BP



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(A)

*[Handwritten signature]*

049058 APR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 06919

1. DECEASED NAME (TYPE OR PRINT) Marie V. Sursock		2a. DATE OF DEATH MONTH DAY YEAR March 30, 1987		2b. HOUR 8:10 P.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1918	
6. AGE (IN YEARS LAST BIRTHDAY) 68		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.A? A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2411 Still Forest Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STATE Maryland			
13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 2411 Still Forest Road, 21208		14. FATHER'S NAME FIRST MIDDLE LAST Mihran Nazaretian			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eugenie Kumar		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Nagi Khouri M.D., Same As #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Colorectal Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>79</u> , to <u>March</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>March 20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William Schlott M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>March 31, 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Schlott M.D.		22e. ADDRESS 9 E. Chase Street, Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-31-87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204			
25a. DATE REC'D. BY REGISTRAR APR - 1 1987		25b. REGISTRAR'S SIGNATURE <u>John P. Anderson</u>			

MEDICAL CERTIFICATION



048549 MAR 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO. 06920

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
ALLEN		M.	SUTTON		3	19	87		6:53p M
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	June 7, 1921			65		MONTHS		DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON	Greater Baltimore Medical Center				Dir. of Personnel		Md. School-Blind		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?				
13a. STATE					13b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. Maryland					13b. Baltimore				
13c. CITY OR TOWN					13c. STREET ADDRESS / ZIP CODE				
Parkton					1111 Molesworth Rd. 21120				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Charles C. Sutton					Hattie Morris				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
Yes					WW II 212-16-2939				
17. INFORMANT					ADDRESS				
Ruth J. Sutton - same as #13c									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PERITONITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HEPATITIS</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/5, 1987</u> to <u>3/19, 1987</u> , that (I) (we) last saw the deceased alive on <u>3/19, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert A. Palermo</u>					DEGREE			22c. DATE SIGNED	
					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			3/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
ROBERT A PALERMO, M.D.					6701 N. CHARLES ST. BALTIMORE, MD. 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			3-24-87		Dulaney Valley		Cockeysville, Balto., Md.		
24. FUNERAL DIRECTOR NAME					ADDRESS		25a. DATE REC'D. BY REGISTRAR		
Ruck Towson Funeral Home, Inc.					1050 York Rd. Towson, Md. 21204		25b. REGISTRAR'S SIGNATURE		
							MAR 26 1987		

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

20% COTTON FIBER



MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06921	
1. DECEASED NAME (TYPE OR PRINT) (Louise N.) Nellie Louise Sutton			2a. DATE OF DEATH MONTH DAY YEAR March 14, 1987		2b. HOUR 7:00 P <sub>M</sub>
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 9 1925	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD		
10. CITY OR TOWN OF DEATH Essex	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2340 Turkey Point Road 21221		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Public Schools
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Short		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Thiele			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218.20.4665		17. INFORMANT ADDRESS Edward N. Sutton (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver and kidney failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>primary melanoma of chest wall</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>					
19a. DATE OF OPERATION <u>primary 7 years</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>melanoma of chest wall</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/8/87</u> , 19 <u>87</u> , to <u>3/15/87</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>3/8/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Gerard M. Woel</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gerard M. Woel		22e. ADDRESS 3315 Pinkney Road			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/16/1987	23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Balto., MD. 21222		25a. DATE REC'D. BY REGISTRAR MAR 16 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

20%

COTTON

FIBER



048831 APR 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Shirley June SWANSON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 30, 1987</b>			2b. HOUR <b>10:40a M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 3, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Conn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Rossville 21237</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION ( <b>"</b> ) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (BEFORE OR AFTER DEATH) <b>Medical Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS, ZIP CODE <b>207 Middleway Rd. Apt 3A 21220</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harold Lundberg</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sally Clair Stokes</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>226 16 0613</b>		17. INFORMANT ADDRESS <b>Robert Burford, Jr. 525 Welbrook Rd. Baltimore, Md. 21221</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic brain lesions</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Agressive small cell carcinoma of the lung</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>March 23</b> , 19 <b>87</b> , to <b>March 30</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>March 30</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>H. Elnahal, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/30/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hany Elnahal, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Dr. Balto. 21237</b>						
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>4/1/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial Gardens</b>		23d. LOCATION TOWN COUNTY STATE <b>Baltimore Co., Md.</b>				
24. FUNERAL DIRECTOR <i>S. Brzadzinski</i> <b>Brzadzinski Funeral Home PA 1407 Old Eastern Ave 21221</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1987</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>				

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Medical Secretary Hospital

207 Madison St. N. A. 21

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207 Madison St. N. A. 21

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Robert Murphy, Jr. Memphis, Tenn. 38103

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No



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06923  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward Sykes			2a. DATE OF DEATH March 2, 1987			2b. HOUR 2:20A. <sup>M</sup>			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9 26 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. Md. <sup>MD.</sup>			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Ruxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Florist		12b. KIND OF BUSINESS OR INDUSTRY 36 Years	
13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 106 Danbury Road 21136				
14. FATHER'S NAME FIRST MIDDLE LAST Harry Sykes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Zuschlog					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 218-09-6021		17. INFORMANT ADDRESS Mrs. Lynette Sykes 106 Danbury Rd. 21136				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION OF GASTRIC CONTENTS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>DEMENTIA</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>November 85</u> to <u>3/2</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>2/23</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Peter S. Tanas</u>			DEGREE <u>M</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>3/2/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter S. Tanas			22e. ADDRESS 420 MED ARTS BLD 101 W. RED ST.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 4, 1987		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Maryland		
24. FUNERAL DIRECTOR NAME Eline Funeral Home Reisterstown, Md. 21136					25a. DATE REC'D. BY REGISTRAR MAR 04 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

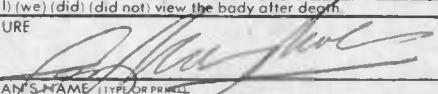
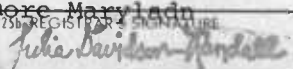
IMPORTANT: When 2-1 is marked or item 18 is signed, the medical examiner must be notified of any other traumatic event, the medical examiner must be notified of any other traumatic event.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked "other," show any injury, or other traumatic event, the medical examiner must be notified before.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RAYMOND JAMES TAWNEY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 29, 1987</b>		2b. HOUR <b>11:15<sup>P</sup>M</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 14 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCK DRIVER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2709 BAY DRIVE 21219</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK TAWNEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MABEL McMANN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>217 07 9965</b>		17. INFORMANT ADDRESS <b>ALVERTA TAWNEY</b> Same as 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>END STAGE LIVER DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEPATO RENAL SYNDROME</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 19, 19 87</b> , to <b>MARCH 29, 19 87</b> , that (I) (we) last saw the deceased alive on <b>MARCH 29, 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3-30-87</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.V.J. VERGHESE, M.D.</b>				22e. ADDRESS <b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-2-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk</b>				24b. ADDRESS <b>7922 Wise Ave. Dundalk MD 21222</b>		25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) <b>MAR 31 1987</b> 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remain a carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		87 06925		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen M. TAYLOR				2a. DATE OF DEATH MONTH DAY YEAR March 14, 1987		2b. HOUR 6:15p <sub>M</sub>			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 11, 1926		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1013 Beech Drive 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Tunis D. Hogue				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma M. Drummond					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		219 22 7405		17 INFORMANT Brenda Atkinson		ADDRESS Daughter Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF pneumonia and lung abscess (c) DUE TO, OR AS A CONSEQUENCE OF chronic obstructive pulmonary disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 25 1987 to March 14 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 14 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sarah L. Owens				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED March 14, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sarah L. Owens M.D.				22e. ADDRESS 9000 Franklin Square Drive					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/16/87		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION BALTIMORE, MARYLAND COUNTY STATE			
24. FUNERAL DIRECTOR Brudzinski Funeral Home PA 1407 Old Eastern Ave.				25a. DATE REC'D. BY REGISTRAR MAR 16 1987					
				25b. REGISTRAR'S SIGNATURE					

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107-11 Eastern Ave.

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MAR 23 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06920

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM EDWIN TAYLOR, SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 20 87</b>		2b. HOUR <b>1:00 PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 27 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS HOSPICE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MAINTENANCE SUPERVISOR STATE OF MARYLAND</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>OLIVER ROSS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GRACE TAYLOR</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO.</b>		16b. SOCIAL SECURITY NO. <b>220-24-1972</b>	
17. INFORMANT <b>CYNTHIA TAYLOR</b>		18. ADDRESS <b>BALTIMORE, MD. 21207</b>		19. STREET ADDRESS / ZIP CODE <b>3312 W. NORTH AVE. BALTIMORE, MD. 21216</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC HEART + NECK CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-12-87</b> to <b>3-20-87</b> that (I) (we) last saw the deceased alive on <b>3-20-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Carla S. Alexander</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3-20-87</b>		22d. ADDRESS <b>Stella Maris Dulaney Valley Rd. - Towson, MD 21204</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carla S. Alexander, M.D.</b>		22f. ADDRESS <b>Stella Maris Dulaney Valley Rd. - Towson, MD 21204</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/24/1987</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SECURITY PROCESS CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>		24. NAME OF FUNERAL HOME, INC. <b>NUTTER &amp; SONS FUNERAL HOME, INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>							

MEDICAL CERTIFICATION

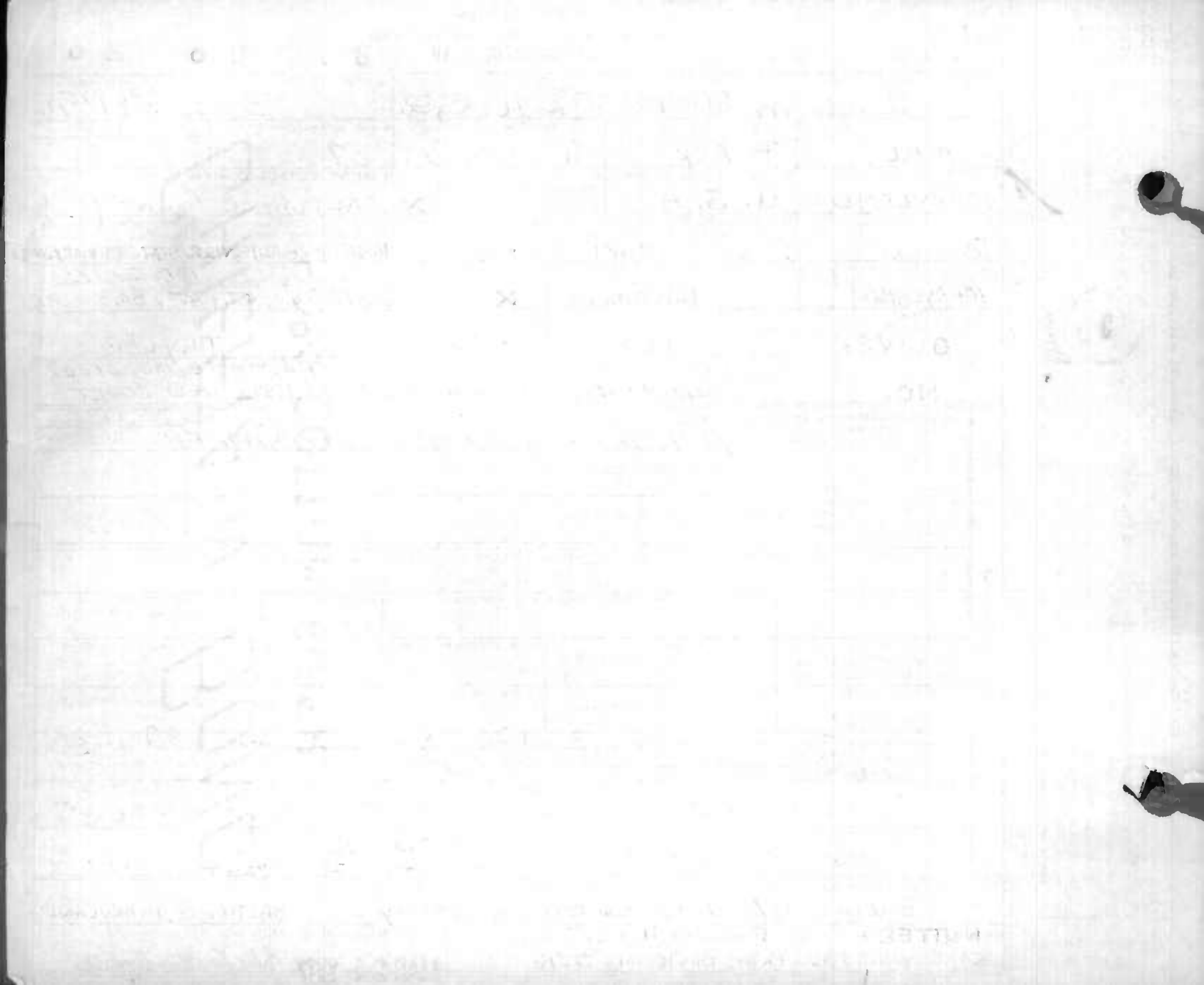
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



048331 MAR 27 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 / REG. NO. 06927

1. DECEASED NAME (TYPE OR PRINT) <b>MILTON H. THOMAS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 22 87</b>		2b. HOUR <b>950 A</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 20 99</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) <b>BALTO. MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CO. MD.</b>		
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>INGLENOCK N.H.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>ELEC. CO.</b>	
13a. USUAL RESIDENCE (IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD.</b> 13c. COUNTY <b>N.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS ZIP CODE <b>3422 WOODSTOCK AVE. 21213</b>	
14. FATHER'S NAME <b>ROBERT THOMAS</b>		15. MOTHER'S MAIDEN NAME <b>MAGGIE UNKNOWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>212-01-1020</b>		17. INFORMANT <b>WONEL SIMPSON</b>		ADDRESS <b>7692 BRIAR LAKE 21222</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>3 mo</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-27-87</b> , 19 <b>87</b> , to <b>3-22</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3-2</b> , 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>David R. Moscar</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-23-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David R. Moscar MD</b>		22e. ADDRESS <b>Arbutus, Md 21227</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>3-24-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO CO. MD.</b>	
24. FUNERAL DIRECTOR (NAME) <b>THOMAS J. SKALDA</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John Gordon-Randall</b>

MEDICAL CERTIFICATION

TO HOSPITAL, CLINIC, TENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21207

100% COTTON - 1100

WIND  
MILL  
1100



046047 MAR 1987

Item # 5,6 12a &amp; 12b Film G 625 3/10/87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 REG. NO.

06923  
5:12 AM

1. DECEASED NAME (TYPE OR PRINT) <b>Retta G. Thomas</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 2, 1987</b>			b. HOUR <b>5:12 AM</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Jan. 19, 1926</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> 62 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
2b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rossville 21237</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Sq. Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Technician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Machine Co.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Baltimore</b>			13c. STREET ADDRESS / ZIP CODE <b>1942 Galena Rd. 21221</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Camp</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Legg</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219 30 2273</b>			17. INFORMANT ADDRESS <b>Albert Thomas, Husband Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>Severe congestive heart failure, diabetes mellitus</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/2 19 78</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/2</b> , 19 <b>78</b> , to <b>3/2</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3/2</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Ernest Arnett</b>			DEGREE <b>MD</b>			22c. DATE SIGNED <b>3/2/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ernest Arnett</b>			22e. ADDRESS <b>9000 Franklin Sq. Drive</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/4/87</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		
23d. LOCATION <b>Belair</b>			23e. LOCATION <b>Harford Co. Md.</b>					
24. FUNERAL DIRECTOR <b>Brudzinski Funeral Home</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 03 1987</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition of the body. Certification for removal of the body from the jurisdiction of the State of Maryland requires the signature of the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before the body is released for burial or cremation.

2-8-62

March 2, 1962

Letter to: [illegible]

Mar. 14, 1962

White

Female

Belmont County

X

USA

West Virginia

[illegible]

Rockville 21337 Franklin Co. District

1962 Census No. 11321

X

Belmont County

Mar. 14, 1962

after Camp

Case

March 14, 1962

SIS NO 21337

to

1

3/15/62

Rockville 21337

Thomas Adams

Enclosed: [illegible] one to [illegible] via [illegible]



046682

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please attach page 3 to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury, if other significant event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Eugenia Merryman Thompson</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>March 6 1987</b>		2b. HOUR <b>1:00 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 16 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaking</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eugene Merryman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Coarse</b>		13e. STREET ADDRESS / ZIP CODE <b>8710 Emge Rd., 21234</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-62-6749</b>		17. INFORMANT ADDRESS <b>John M. Thompson, 14905 Northcote Ln. 20716</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dementia</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Two weeks</b> <b>years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 1982</b> , to <b>3-6 1987</b> , that (we) last saw the deceased alive on <b>3-6 1987</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>George Lowe</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>3-9-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Lowe, M.D.</b>				22e. ADDRESS <b>3703 Belair Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/9/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sherwood Epis. Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Terdiman-Rudman</b>			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06730

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
STEPHEN VINCENT THORN						3. SEX			4. RACE			5. DATE OF BIRTH		
Male			White			7-18-1934			52 YRS.			6. AGE (IN YEARS LAST BIRTHDAY)		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA						Baltimore County			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Randallstown			Baltimore County General Hospital			Crane Operator			Seagrams					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland			Baltimore			Woodlawn			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2001 Oak Dr. 21207		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Joseph			Thorn Sr			unknown			Yes			Korea		
215-30-3302			Susan			Baltimore, MD 21207			Mrs. Mary E. Thorn			1219 Stella Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
				P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE				3-28-87		
Margarita A. Korell, M.D.				Assistant				MEDICAL EXAMINER				SIGNED		
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial				3-31-87				Woodlawn Cemetery				Woodlawn Baltimore MD		
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Loring Byers, Funeral Directors, Inc				MAR 31 1987				Julia Davidson-Korell						
8728 Liberty Rd. Randallstown, MD 21133														

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. THIS FORM SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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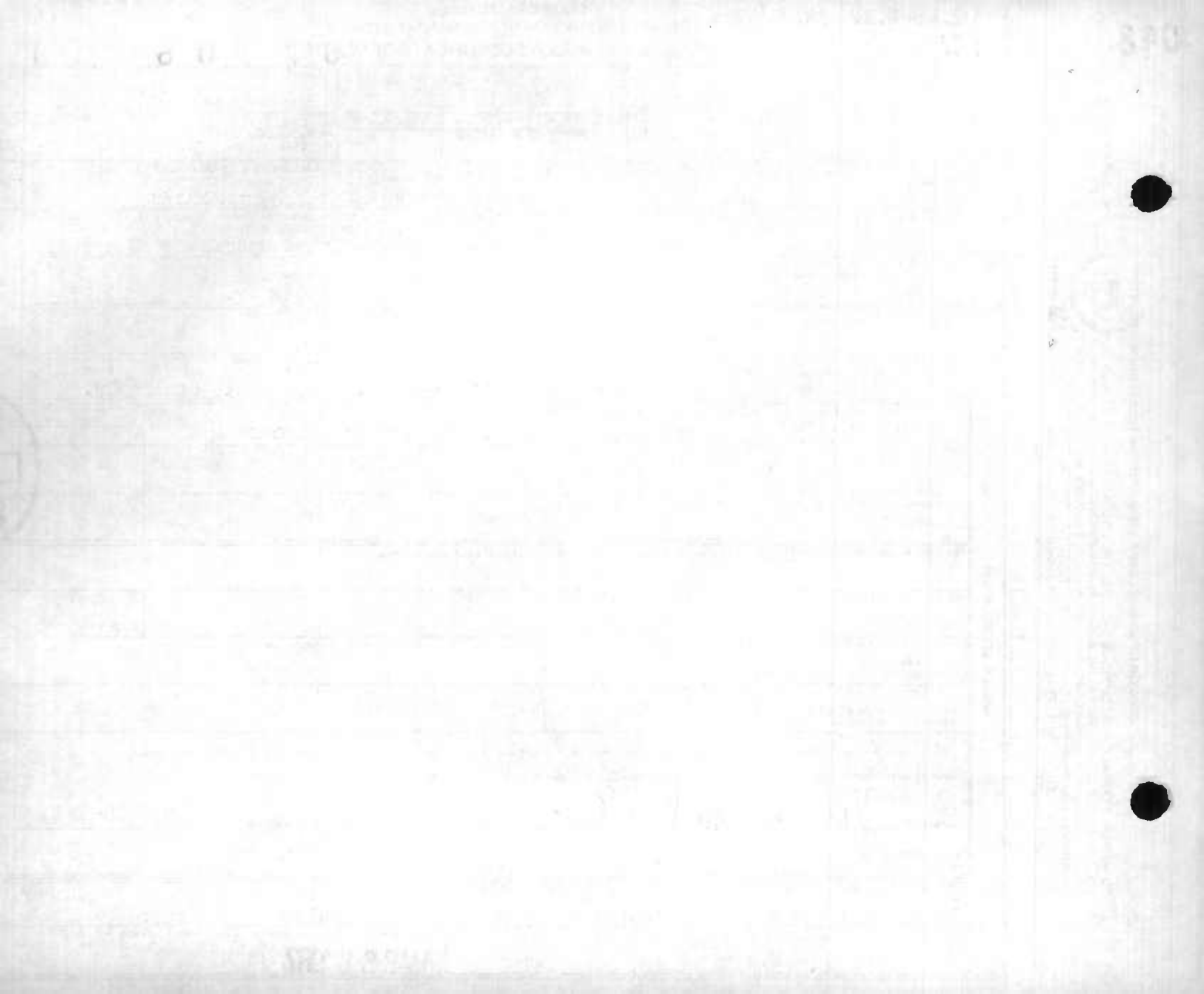
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other significant event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>VERNA L. THRASHER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 04, 1987</b>			2b. HOUR M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 07, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO. MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CO. MD.</b>			
10. CITY OR TOWN OF DEATH <b>PARKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2910 ONYX ROAD 21234</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNT.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO. CO.</b>		13c. CITY OR TOWN <b>PARKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2910 ONYX ROAD 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>TURNER TRIPPE BEST</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VERNA MAY MAN'SFIELD</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-26-7146</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic adenocarcinoma</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months.</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 16, 1986</b> , to <b>March 4, 1987</b> , that (I) (we) lost saw the deceased alive on <b>Dec. 24, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paul Chang, MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>3/5/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. PAUL CHANG</b>				22e. ADDRESS <b>Good Samaritan Hospital, Balto, Md. 21209</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-7-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PARKVILLE BALTO. CO. MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>EVANS CHAPEL OF MEMORIES, PARKVILLE</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 05 1987</b>		25b. REGISTRAR <b>Julius [Signature]</b>			

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048802 APR

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06932  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thelma Sadie Toepfner			2a. DATE OF DEATH MONTH DAY YEAR 3-24-87		2b. HOUR 10:15 PM				
3. SEX Female		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 12 - 31 - 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.			
10. CITY OR TOWN OF DEATH Baltimore Co.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian-Heritage Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2503 Ambler Road 21222	
14. FATHER'S NAME FIRST MIDDLE LAST George Greensfelder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-30-4779		17. INFORMANT ADDRESS Donald K. Toepfner 2503 Ambler Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Admitted Anticoagulant</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular disease.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Patrick V. Patterson</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick V. Patterson				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-28-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk				25a. DATE REC'D. BY REGISTRAR MAR 31 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)



DATE: 10/10/2010

TIME: 10:10

LOCATION: 101-101

DESCRIPTION: 101-101

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06733

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WARREN C Tolbert			2a. DATE OF DEATH MONTH DAY YEAR 3/18/87		2b. HOUR M
3. SEX MALE	4. RACE CAU.	5. DATE OF BIRTH MONTH DAY YEAR 07 03 30		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore county MD.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SC JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY BALTIMORE	13c. CITY OR TOWN Middle River	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Clyde W. Tolbert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Kope			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 47-51		17. INFORMANT ADDRESS MayBelleTolbert 109GliderDr.21220	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) Chronic liver & massive GI bleeding					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-05, 19 87, to 3-18, 19 87, that (I) (we) last saw the deceased alive on 3-18, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE VENIEDO ALIDIO MD		DEGREE		22c. DATE SIGNED 3-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 6010 YORK RD 21212			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/21/87	23c. NAME OF CEMETERY OR CREMATORY HollyHillCemetery		23d. LOCATION CITY OR TOWN COUNTY STATE MiddleRiver Balto. Md.
24. FUNERAL DIRECTOR NAME ConnellyFuneralHome			25a. DATE REC'D. BY REGISTRAR MAR 20 1987		
ADDRESS 300 Mace Ave. 21221			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon and return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the coroner may be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		87 REG. NO. 06934									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ITZELL		B		TOSCANO				3 2 87		8:23 <sup>P</sup>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
F		W		11 11 11		75 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
TENNESSEE		U.S.A.				BALTIMORE Co MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON, MD		TOWSON, MD						NURSE		V.T. MEADE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		BALTIMORE		BALTO				2303 PENTLAND AVE APT. 402		21234	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
ANTONIO		RENFROE		DOLORES		UN'KNOW'N					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
NO		264-26-8709		EDITH LUACES		2304 PINEWOOD AVE		21214			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Acute congestive heart failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic heart disease.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/11 1987, to 3/12 1987, that (I) (we) last saw the deceased alive on 3/12/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE HOMER MOGAREE M.D.				22c. DATE SIGNED 3/2/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOMER MOGAREE				22e. ADDRESS 3455 WILKENS AVE. 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR 5, 1987		23c. NAME OF CEMETERY OR CREMATORY MOST HOLY REDEEMER BALTO.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME LILLY + ZEILER INC.		ADDRESS 1901 EASTERN AVE 21231		25a. DATE REC'D. BY REGISTRAR MAR 10 1987		25b. REGISTRAR'S SIGNATURE					

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MAR 31

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 0 6 9 3 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Joseph D. Trageser				March 26, 1987		12:45 P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.
Male	White	June 23 1908		78			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland	Towson	Multi-Medical Center	Ret		Railway Express		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5101 Plymouth Rd. 21214			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE YEAR OR DATES			
Charles Trageser		Mary (son) Trageser		yes W.W. 11			
17. INFORMANT		18. SOCIAL SECURITY NO.		19. ADDRESS			
David Trageser		212-03-8422		6048 Kenilworth Dr. Towson Md			
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Prostate Cancer							
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 85 to 3 19 86, that (I) (we) last saw the deceased alive on 3 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (I) (did) (did not) sign the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
[Signature]		M.D.		3/26/87		Alan Shorofsky M.D.	
22e. ADDRESS		22f. ADDRESS					
660 Kenilworth Drive, Towson, Maryland 21204							
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Mar. 30, 1987		Holy Redeemer Cem.		Baltimore City Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck Funeral Home, Inc. Balto., Md.				MAR 30 1987		[Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="display: flex; justify-content: space-between;"> <div>           047228 MAR 13 1987         </div> <div>           FOR STATE REGISTRAR         </div> <div>           87 06936 REG. NO.         </div> </div>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SHARON D TROGDON						20. DATE OF DEATH MONTH DAY YEAR 03 10 87 2b HOUR 725A			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 04 15 57		6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co, MD			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) disabled		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4747 Bonnie Brae Rd. 21208	
14. FATHER'S NAME FIRST MIDDLE LAST Randolph J. Trogon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Marshall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Thelma Neal 4747 Bonnie Brae Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>aspiration</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>① mention @ Mental Incapacitation</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/26/1986</u> to <u>03/10/1987</u> , that (I) (we) last saw the deceased alive on <u>03/10/1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>						DEGREE MD		22c. DATE SIGNED 03/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. E. NOUR						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/13/87		23c. NAME OF CEMETERY OR CREMATORY Druidridge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Md.		
24. FUNERAL DIRECTOR NAME Wm C. March F/H West						ADDRESS 4300 Wabash Ave.		25a. DATE REC'D. BY REGISTRAR MAR 13 1987	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

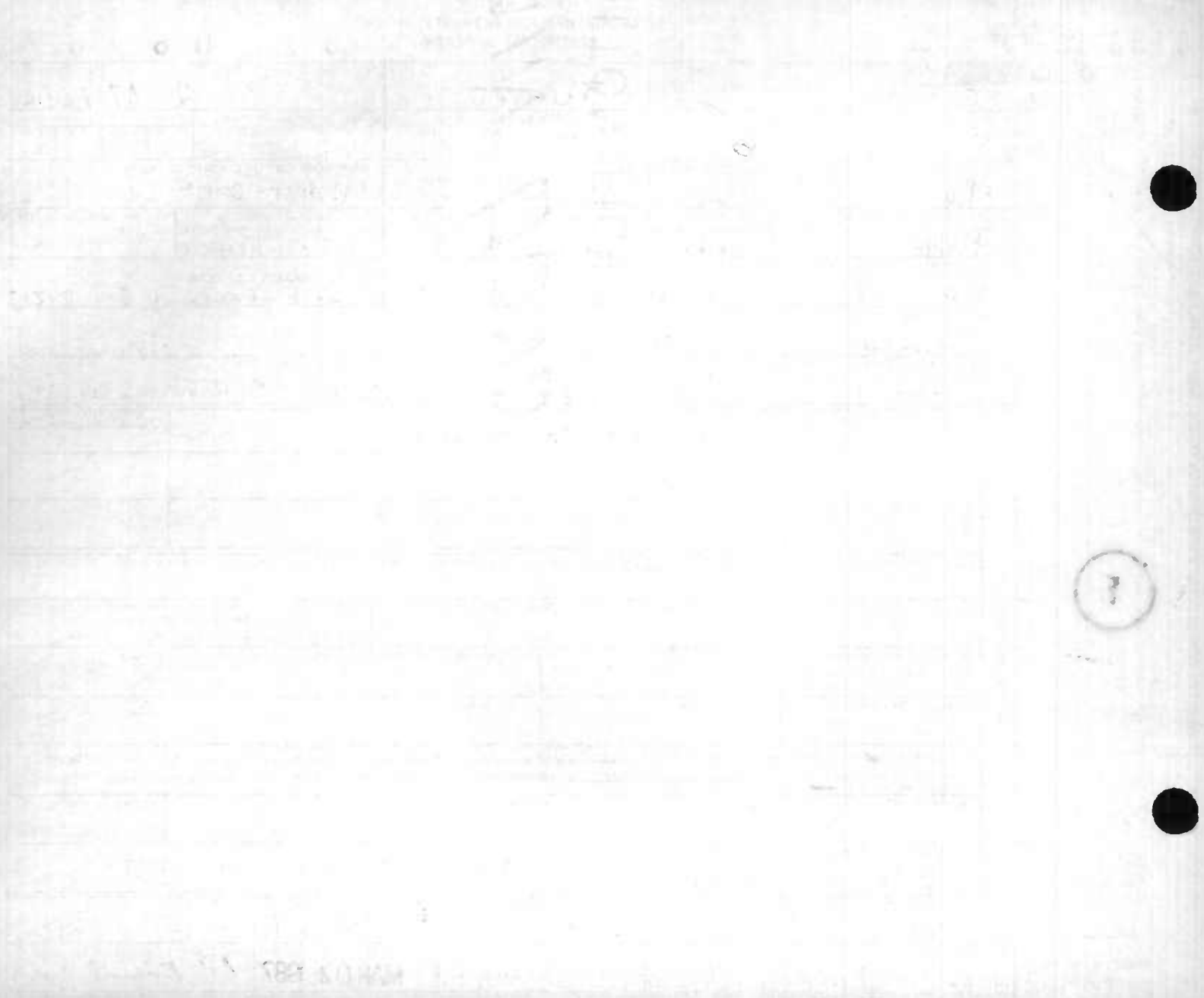
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP. \_\_\_\_\_

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06937

1. DECEASED NAME (TYPE OR PRINT) <b>Estella Turner</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 2 87</b>			2b. HOUR <b>7:05 AM</b>			
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 9 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
11. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>F.S.K. - RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2302 E. FEDERAL ST. 21213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE JENKINS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE THOMPSON</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16a. <b>—</b>				16b. SOCIAL SECURITY NO. <b>21212 5778</b>		17. INFORMANT ADDRESS <b>LANE T POWELL 1564 Waverly Way 21239</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital attended the deceased from <b>February 7</b> , 19 <b>87</b> , to <b>March 2</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>March 2</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.									
22b. SIGNATURE <b>George Nebaji</b>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Nebaji</b>				22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/6/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel MD</b>		
24. FUNERAL DIRECTOR NAME <b>MARCH Funeral Home</b>				ADDRESS <b>1101 North Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 04 1987</b>		25b. REGISTRAR'S SIGNATURE <b>A. J. Davidson-Randall</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 06938	
1. DECEASED NAME (TYPE OR PRINT) Jeanette Bosley UCKER		2a. DATE OF DEATH March 21, 1987		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 4, 1906	
6. AGE (IN YEARS (LAST BIRTHDAY)) 80		8. IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD	
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3021 Willoughby Road 21234		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical	
12b. KIND OF BUSINESS OR INDUSTRY Exxon Corp.		13a. STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3021 Willoughby Road 21234	
14. FATHER'S NAME FIRST MIDDLE LAST John Fulton Bosley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lida Boyer Downes		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 212-07-0666		17. INFORMANT James P. Bosley		ADDRESS 3415 Northern Parkway 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>77</u> , to <u>Mar.</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Mar. 20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Elliott Harris</u>		DEGREE MD		22c. DATE SIGNED Mar 23, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elliott Harris, MD		22e. ADDRESS 8100 Harford Road Baltimore, MD 21234			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 24, 87		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc. 7110 Belair Road Baltimore, Maryland 21206			
25a. DATE REC'D. BY REGISTRAR MAR 23 1987		25b. REGISTRAR'S SIGNATURE <u>Anderson-Randall</u>			

20% COTTON FIBER

EXHIBIT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Josephine UMPHLETT					2a. DATE OF DEATH MONTH DAY YEAR March 27, 1987		2b. HOUR 2:45A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR NOV. 2 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 333 Lorraine Ave. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST John A. Simpson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Shane							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-10-4112		17. INFORMANT ADDRESS Charles Umphlett 419 Lorraine Ave.					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction secondary to occlusion of left anterior descending artery DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of right upper lobe of lung with involvement of trachea DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from March 23, 1987, to March 27, 1987, that (I) (we) last saw the deceased alive on March 27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE JAY DON STERN				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAY DON STERN				22e. ADDRESS 9000 Franklin Square Drive, 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/30/87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto. Md.			
24. FUNERAL DIRECTOR NAME Connelly Funeral Home				ADDRESS 300 Mace Ave. 21221		25a. DATE REC'D. BY REGISTRAR MAR 31 1987		25b. REGISTRAR'S SIGNATURE Julia T. ...	



TOP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO. 06940

1. DECEASED NAME (TYPE OR PRINT) <b>CARRIE W. UNGUREIT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 07, 1987</b>			2b. HOUR <b>12:30 P.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02/20/08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>Essex</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Riverview Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Eggeners</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Wachter</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Keyes</b>			13e. STREET ADDRESS / ZIP CODE <b>7308 North Dakota A21219</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>218-12-7419</b>		17. INFORMANT <b>Audrey Garst</b>			ADDRESS <b>7308 N. Dakota Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>18 Aug 1983</b> to <b>7 March 1987</b> , that (I) (we) last saw the deceased alive on <b>3 March 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. Rainess</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-7-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORRIS RAINESS, MD.</b>			22e. ADDRESS <b>1105 OLD EASTERN AVE 21221</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/10/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Eastwood Balto Co. Md.</b>		
24. FUNERAL DIRECTOR <b>Chas. S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 09 1987</b>				
					25b. REGISTRAR'S SIGNATURE <b>Julia Anderson-Kendall</b>				

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please detach and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other information, the medical examiner must be notified at once.

NOTICE

NOTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Dorothea F. Utzinger</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>March 31, 1987</b>		2b. HOUR M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01/11/05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.			
10. CITY OR TOWN OF DEATH <b>Arbutus</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1262 Vogt Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>retail</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1262 Vogt Ave. 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N</b>		16b. SOCIAL SECURITY NO. <b>218-36-4082</b>		17. INFORMANT ADDRESS <b>Theodore Utzinger 1256 Maple Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Coronary Vessel Disease</b> YRS DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> YRS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>Left Ventricular Hypertrophy, osteoarthritis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 31</b> , 19 <b>85</b> , to <b>March 31</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>Jan 7</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gregory L. Taylor MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>4/11/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Gregory L. Taylor MD.</b>				22e. ADDRESS <b>4713 Leeds Ave. Arbutus, Md. 21227</b>					
23a. BURIAL, CREMATION, REMOVAL <b>burial</b>		23b. DATE <b>04/03/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Md.</b>			
24. FUNERAL DIRECTOR <b>AMBROSE FUNERAL HOME 1328 SULPHUR SPRING RD</b>				25a. DATE REC'D. BY REGISTRAR <b>APR - 2 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>			

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 06942

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HELEN VANKO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-16-87</b>		2b. HOUR <b>630A</b> M	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12-5-1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>AUSTRIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO., CO.</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DULANEY-TOWSON NURSING CTR.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. CITY OR TOWN <b>BALTO.</b>		13c. STREET ADDRESS <b>21224 616 N. STREEPER ST.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH SHANTA</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIE KLESNER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-34-8780</b>		17. INFORMANT ADDRESS <b>Mrs. John J. Vanko - 120 Springdale Dr. 21093</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD with recent CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2th yr</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7501 York Road Towson, Md. 21204</b>	
22a. I certify that (I) (the hospital) attended the deceased from <b>16 January 1987</b> to <b>16 March 1987</b> , that (I) (we) lost saw the deceased alive on <b>16 March 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			

22a. SIGNATURE <b>Charles F. O'Donnell</b>	DEGREE <b>ATTENDING PHYSICIAN</b>	22c. DATE SIGNED <b>3/17/87</b>
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles F. O'Donnell, M.D.</b>		22d. ADDRESS <b>7501 York Road Towson, Md. 21204</b>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>3-19-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BOHEMIAN NATIONAL</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD.</b>
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24. FUNERAL DIRECTOR NAME <b>Hattie Miller - 7527 Laurel Rd.</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1987</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Vanko</b>
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MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

06943

1. DECEASED NAME (TYPE OR PRINT) <b>Louise S. Vaughan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03/07/87</b>			2b. HOUR <b>4:50P M</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>5-11-04</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Towson</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Orren Smith</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Starkloff</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		
16b. SOCIAL SECURITY NO. <b>216-24-3383</b>			17. INFORMANT ADDRESS <b>Nancy Coffman 227 Canal Park Dr. Salisbury Md.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3/7/87</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2/19</b> , 19 <b>87</b> , to <b>3/7/87</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>3/7/87</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Karl C. Golink</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/7/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Karl C. Golink</b>			22e. ADDRESS <b>GBMC 6701 N. Charles St</b>					

## MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>03/10/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson Baltimore Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Holloway/FUNERAL Home Sul. md</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate to Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>SPURGEON R. VAUGHN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3-17-87</b>		2b. HOUR <b>2:46 AM</b>		
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-27-97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. Gen.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Old Court Nursing Ctr. 21133</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aaron Vaughan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Sue</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>28-10-7980</b>		17. INFORMANT <b>Ernestine Davenport 3917 Dolfield Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIC - PULMONARY Edema -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RENAL FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>INTESTINAL OBSTRUCTION</b>									
19a. DATE OF OPERATION <b>3-12-87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>acute Abdomen -</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3-5-87</b> , to <b>3-17-87</b> , that (I) (we) last saw the deceased alive on <b>3-17-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. Depestre</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3-17-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. DEPESTRE</b>				22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-21-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonville, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H West</b>				ADDRESS <b>4300 Wabash Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John Beardon-Keadle</b>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

047497 MAR 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06945					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stella R. Verbus				2a. DATE OF DEATH MONTH DAY YEAR March 15 1987				2b. HOUR 5:30am	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 1 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 417 Virginia Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 417 Virginia Ave. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Raychel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Krukar					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 217-26-5816		17. INFORMANT ADDRESS William Verbus 417 Virginia Ave. 21221					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 4 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>82</u> , to <u>March 15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Jan. 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE <u>Paul Chang, MD</u>				DEGREE				22c. DATE SIGNED <u>3/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul Chang, MD</u>				22e. ADDRESS <u>5601 Loch Raven Blvd, Balto, Md. 21239</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/18/87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Rossville Baltimore Md/			
24. FUNERAL DIRECTOR NAME Connelly Funeral Home				ADDRESS 300 Mace Ave. 21221		25a. DATE RECEIVED BY REGISTRAR <u>MAR 17 1987</u>			

C. D.

100-100000

STANDARD FORM NO. 64  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27

(A)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove a non-identical. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 06940

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LOUISE VIEWEG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-06-87</b>			2b. HOUR <b>7:40 A</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-12-1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>101</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE-ROSSVILLE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. CITY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4233 SOTH AVE, 21236</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ADAM GOETZ</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BARBARA DENNERT</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>216-24-1089</b>		17. INFORMANT <b>SAME ADDRESS AS ABOVE</b> <b>KATHERINE POLLHAMER</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Compensated Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic heart disease</b> Approximate interval between onset and death										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Ischemic heart disease Hypertension</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 1</b> 19 <b>86</b> , to <b>March 6</b> 19 <b>87</b> , that (I/we) last saw the deceased alive on <b>Feb 1</b> 19 <b>87</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Howe H. Bond</b>			DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3-6-87</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. HOWARD BOND, MD</b>			22e. ADDRESS <b>9618 BELAIR RD - 21236</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/9/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>SCHIMUNEK FUNERAL HOME, 3331 BREHM'S LANE, BALTO 19708</b>										

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8706947  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Albert Vogt</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>March 15, 1987</i>		2b. HOUR A. <i>1:15</i> M.	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 22 00</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Germany</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Rosedale</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5906 Kenwood Avenue</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Barber</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self-Employed</i>
13a. STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Rosedale</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Heinrich Vogt</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>? ? ?</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-10-4959</i>		17. INFORMANT ADDRESS <i>Albert K. Vogt 5906 Kenwood Ave. 21237</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1984</i> , 19____, to <i>March</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>March</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Adoracion B. Paulino</i>		DEGREE		22c. DATE SIGNED <i>3/17/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Adoracion B. Paulino</i>		22e. ADDRESS <i>3005 Conkleig Trail, Md. 21224</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Entombment</i>		23b. DATE <i>3-17-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>	
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler &amp; Son Inc.</i>		ADDRESS <i>6224 Eastern Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 17 1987</i>	
				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

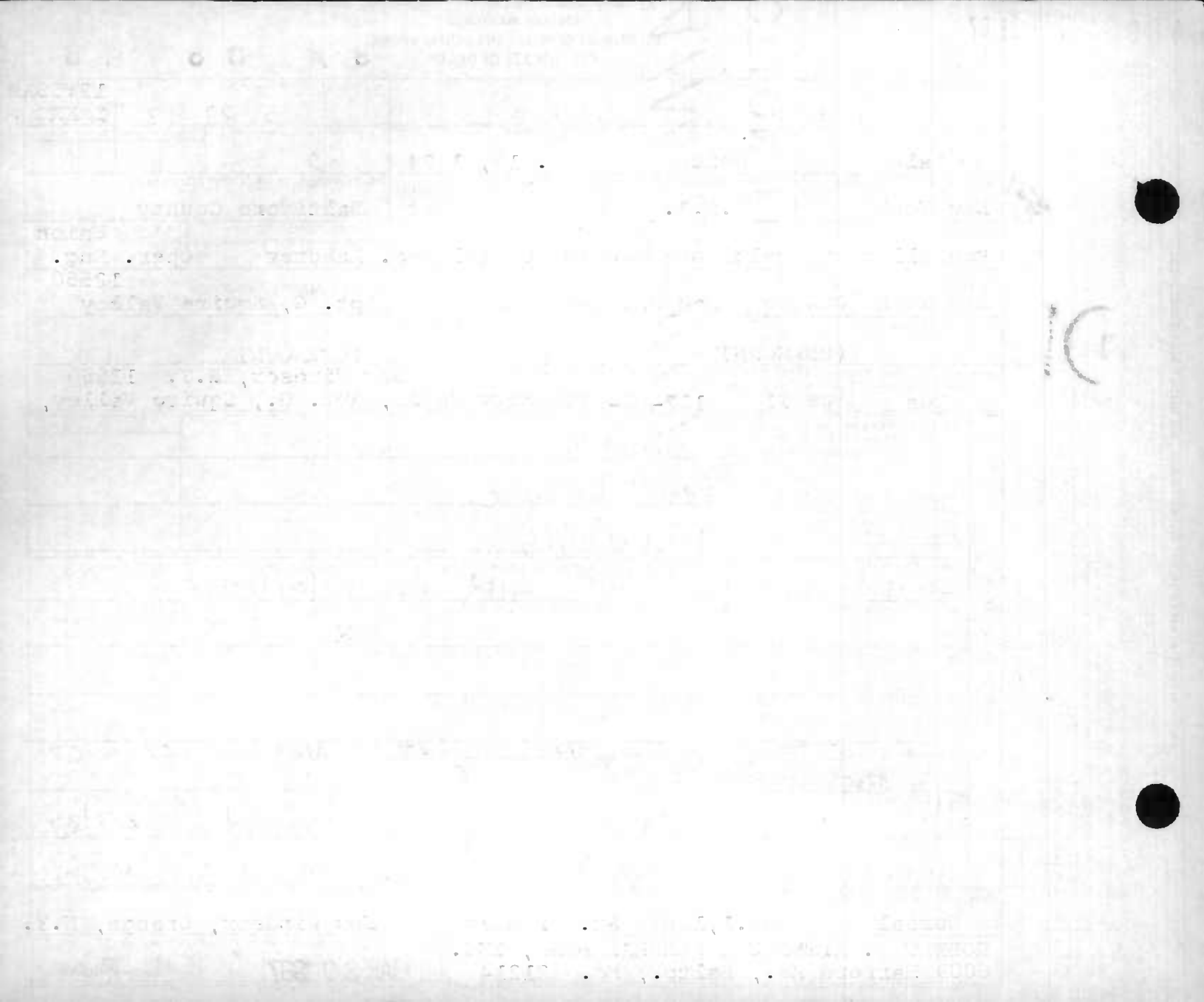


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. TIME OF DEATH HOUR MIN.	
JOSEPH		VOJIR						3 27 87		12:55AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		Feb. 17, 1924		63 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Randallstown		Baltimore County General Hos.									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Laborer		Oper. Eng.									
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE		13e. STREET ADDRESS / ZIP CODE			
New York		Orange		New Windsor		Apt. G, Squire Valley		79999-12550			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
(UNKNOWN)				(UNKNOWN)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				WW II		New Windsor, N.Y. 12550					
				132-05-5770		Mary Vojir, Apt. G., Squire Valley.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) shock.											
DUE TO, OR AS A CONSEQUENCE OF (b) Resp. failure											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) Aerolosis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
Rhabdomyolysis M.T. mild Renal failure.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/23 19 87, to 3/27 19 87 that (I) (we) last saw the deceased alive on 3/27/87 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did / did not view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Hafeez A. Syed M.D.								3/27/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
HAFAEEZ A SYED M.D.		BALTIMORE COUNTY GEN HOSP.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Apr. 1, 1987		St. Francis		New Windsor, Orange, N.Y.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214						MAR 30 1987		[Signature]			



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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS C Vondersmith</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>3-30-1987</b>		7b. HOUR <b>5:38 PM</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-17-1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>70</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman- Balto.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gas and Electric</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Vondersmith</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel Hooker</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>W W 2 214-01-5458</b>		17. INFORMANT <b>Mrs. Linda Peregrino</b> Route 3 Box 173 Front Royal, VA. 22630					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic small cell ca of</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>the lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3-20</b> , 19 <b>87</b> , to <b>3-30</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3-30</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Allen J. Church M.D.</b>					DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3-30-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen J. Church M.D.</b>					22e. ADDRESS <b>Balt. County General Hosp</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/3/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>					25a. DATE RECEIVED BY REGISTRAR <b>APR 03 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Tindon-Randall</b>			
8728 Liberty Road Randallstown, MD. 21133										

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THE UNIVERSITY OF CHICAGO  
LIBRARY

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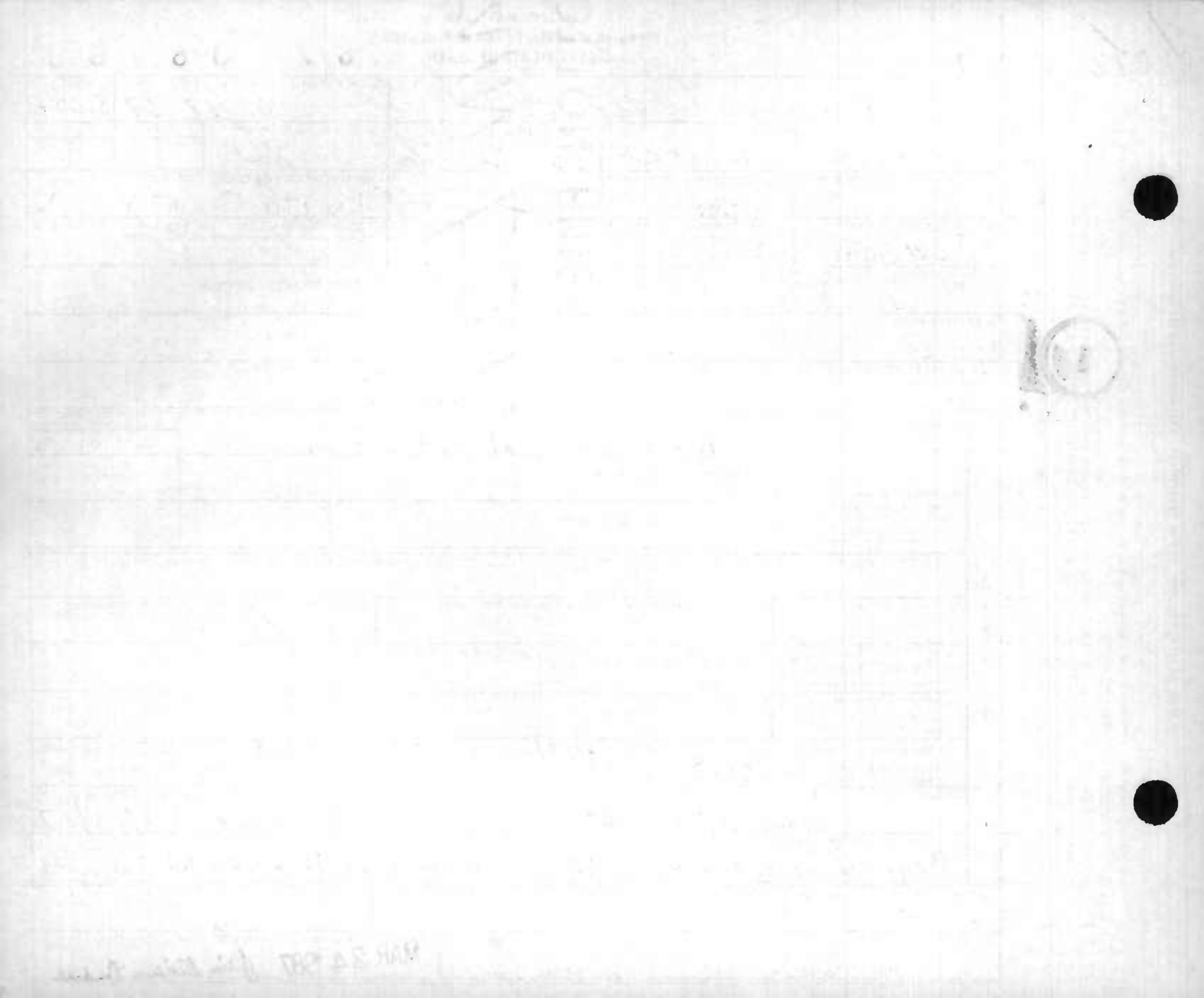




STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 06950

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Florence Vorsteg</u>		MONTH DAY YEAR <u>03 18 87</u>		<u>8:05 PM</u>	
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>06 22 06</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>80</u> YRS	IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balto County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Towson</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St. Joseph's</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Cook</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Cafeteria</u>
13a. STATE <u>Maryland</u>		13b. COUNTY <u>BALTO</u>	13c. CITY OR TOWN <u>Balto.</u>	13d. INSIDE CITY (SUITS)? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Patrick Byrne</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ann Cannon</u>		13e. STREET ADDRESS / ZIP CODE <u>7809 Wendover Ave. 21234</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <u>214-20-7954</u>	17. INFORMANT <u>Mr. James O'Hare</u>		ADDRESS <u>Balto., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (SAY HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18/87</u> to <u>3/18/87</u> that (I) (we) last saw the deceased alive on <u>3/18/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Raymond Henry Plazek, Jr MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/18/87</u>	
23a. BURIAL, CREMATION, REMOVAL (CHECK) <u>Removal</u>		23b. DATE <u>3-19-87</u>		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME <u>State Anatomy Board</u>		ADDRESS <u>Balto., Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 24 1987</u>	
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rudolph</u>	



046966 MAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRECILIATED AREA 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. WITH FOR PAGES 1, 2, AND 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. INSTEAD OF PAGE 1, SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. BEFORE BURIAL, CREMATION, OR REMOVAL.

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 DHMH - 17  
 (VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06951

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/>		MONTH		DAY		YEAR		2b. HOUR			
Jessica		Darlin		Wagner						3-3		1987				M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		7d. HOUR			
Female		White		Nov. 10 1986		YRS. 3 21						3-3 1987				5:10 a.m.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				USA								Baltimore County, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Rossville				Franklin Square Hospital				-				-							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland				Balto.				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3 Paula Place Apt. 3A, 21237			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
James Robert Wagner				Denise Letitia Schafer															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS				21237			
No				-				-				James R. Wagner, 3 Paula Place Apt. 3A							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
22b. TITLE (SPECIFY) Assistant																			
ACTUAL SIGNATURE				MEDICAL EXAMINER										DATE SIGNED					
Dennis F. Smyth, M.D.				111 Penn. St., Balto., Md. 21201										3-3-87					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN							
Burial				3/6/87				Dulaney Valley Mem. Gardens				Timonium Balto. Md.							
24. FUNERAL DIRECTOR (NAME)				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
J. E. Lowell Lemmon				10 W. Padonia Rd.				MAR 10 1987				Julia Deaton-Rubner							



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 and file with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked on item 19 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06952

1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS P. WAGNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 30 87</b>			2b. HOUR <b>11:20 PM</b>			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 20 97</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>12 20 1897</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE Co. MD.</b>			
10 CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REPAIRMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO CO</b>		13c. CITY OR TOWN <b>PARKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS WILLIAM WAGNER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA LOUISE HOERR</b>			13e. STREET ADDRESS / ZIP CODE <b>8416 NUNLEY DRIVE 21234</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>W.W.# 212-03-3365</b>		17 INFORMANT ADDRESS <b>FAMILY RECORDS</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ISCHEMIC and ARTERIO-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>-SCLEROTIC CARDIO-</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>VASCULAR DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>? yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>19 80</b> to <b>3-30</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3-30</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A.H. Ghiladi</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-1-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A.H. GHILADI, MD.</b>			22e. ADDRESS <b>7600 OSLER Dr. Towson 21204</b>						
23a. BURIAL, CREMATION, REMOVAL (METHOD) <b>BURIAL</b>			23b. DATE <b>04-02-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PARKVILLE BALTO CO. MD.</b>		
24. FUNERAL DIRECTOR <b>EVANS CHAPEL OF MEMORIES</b>						25a. DATE REC'D. BY REGISTRAR <b>APR - 3 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Alexander R. Rader</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic etiology, medical examiner must be contacted at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>MARIAN WALDIE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 25, 87</b>			2b. HOUR <b>A</b> <b>2:45</b> M	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 1, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Unknown</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Balto. City</b> 13c. CITY OR TOWN <b>Baltimore</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5220 York Road Apt. 10A 21212</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Cleavland</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth W. Winter</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-07-9057</b>		17. INFORMANT <b>Mrs. Regina Lipman</b> ADDRESS <b>301 West Preston Street Balto. MD. 21201</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Renal failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 8, 1987</b> to <b>March 25, 1987</b> , that (I) (we) last saw the deceased alive on <b>March 25, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Shassem Pourmotabbed, M.D.</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3-25-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GHASSEM POURMOTABBED</b>					22e. ADDRESS <b>Balto. Co. General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/27/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

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049183 APR 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06954  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CARRIE E. WALKER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 26, 1987</b>			2b. HOUR <b>1:40</b> M.			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 3, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Ruxton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE - Ruxton</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Carroll</b> 13c. CITY OR TOWN <b>Westminster</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>712 Hook Road 21157</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH G. Nisman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CARRIE LANG</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>21446 8398</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS - aspiration pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>urinary tract infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. U. N.</b>				DEGREE				22c. DATE SIGNED <b>MARCH 27, 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. LELIAN E. PARRA</b>				22e. ADDRESS <b>7122 HARFORD ROAD - PARKVILLE</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3-28-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LODGE PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPEL OF CHIMES</b> ADDRESS <b>YORK ROAD</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Lelia T. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

BP \_\_\_\_\_

CONFIDENTIAL

1. The first of the three main points of the report is that the United States has a long and honorable tradition of supporting the people of the Western Hemisphere in their struggle for independence and freedom.

2. The second point is that the United States has a long and honorable tradition of supporting the people of the Western Hemisphere in their struggle for independence and freedom.

3. The third point is that the United States has a long and honorable tradition of supporting the people of the Western Hemisphere in their struggle for independence and freedom.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card No. 10 (page 1) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARIE E. WALKER</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>3 24 87</b>				2b. HOUR <b>1:30 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 16 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> County MD.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6019 OLD HARFORD RD 21214</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Lastner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Rudtinger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>212-74-9862</b>		17. INFORMANT ADDRESS <b>Mr. Franklin J. Walker Sr. 4511 Parkwood Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute congestive heart failure</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/19 1987</b> to <b>3/24 1987</b> , that (I) (we) last saw the deceased alive on <b>3/24 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Nestor M. Carmona</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/24/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NESTOR M. CARMONA</b>				22e. ADDRESS <b>6012 Harford Rd., Balto., Md. 21214</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Mar. 27, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1987</b>		25b. REGISTRAR'S SIGNATURE <b>James Davidson-Randall</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 06956

1. DECEASED NAME (TYPE OR PRINT) Harold Milford Wall			20. DATE OF DEATH MONTH DAY YEAR March 11, 1987			21. HOUR 9:30a M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 17, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Highway Division Balto. Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harold B. Wall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leila Simmons		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II			
16b. SOCIAL SECURITY NO. 006-18-3662		17. INFORMANT ADDRESS Phyllis M. Wall 2402 Cooper Ave. 21219					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Poorly differentiated squamous cell carcinoma</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>March 1</u> , 19 <u>87</u> , to <u>March 11</u> , 19 <u>87</u> , that <u>we</u> (we) lost saw the deceased alive on <u>March 11</u> , 19 <u>87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Joseph Kaplan</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/11/87</u>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Kaplan, M.D.		23b. ADDRESS 9000 Franklin Square Dr., Balto., 21237					
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE 3-14-87		23e. NAME OF CEMETERY OR CREMATORY Holly Hill		23f. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		25a. DATE REC'D. BY REGISTRAR MAR 16 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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THE NEW YORK  
STATE OF NEW YORK  
STATE OF NEW YORK

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06957  
REG. NO.

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST GRACE T. WALTER		2b. DATE OF DEATH MONTH DAY YEAR 3-10-87		2b. HOUR 10:30AM	
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 11 05 97		6. AGE (IN YEARS LAST BIRTHDAY) 89		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3723 Courtleigh Dr. 21133	
14. FATHER'S NAME FIRST MIDDLE LAST John G. Ochs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth C. Wills		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-05-0348		17. INFORMANT ADDRESS Randallstown MD 21133 Miss Teresa B. Walter 3723 Courtleigh Dr.	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cervical Tract infection</u>							
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-27-2-1987</u> to <u>3-10-1987</u> , that (I) (we) lost saw the deceased alive on <u>3-10-1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Sig</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAAFAT GIRGIS		22e. ADDRESS Baltimore County Gen Hosp							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-13-87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.		25a. DATE REC'D. BY REGISTRAR MAR 12 1987		25b. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

80% COTTON FIBER

WILSON POWER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR 4/21/87 sb 87 06758 REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUBIN S. WARANCH						2a. DATE OF DEATH MONTH DAY YEAR MARCH 25, 1987		2b. HOUR 6:30 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV. 11, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7915 IVY LANE 21208				12a. USUAL OCCUPATION (TYPE OF WORK, INCLUDING 104 WORKING LIFE) PRESIDENT		12b. KIND OF BUSINESS OR INDUSTRY COMMERCIAL LAUNDRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7915 IVY LANE 21208	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC WARANCH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 820-06-8218 212-10-2871		17. INFORMANT ADDRESS MRS. EVELYN WARANCH 7915 IVY LANE 21208			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma - 1<sup>st</sup> site unknown</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1986</u> to <u>March 25, 1987</u> , that (I) (we) last saw the deceased alive on <u>March 16, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David S. Ettinger M.D.				DEGREE M.D.				22c. DATE SIGNED 3/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID S. ETTINGER M.D.				22e. ADDRESS The Johns Hopkins Oncology Center Balto M					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/27/87		23c. NAME OF CEMETERY OR CREMATORY BETH EL MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215				25a. DATE REC'D. BY REGISTRAR MAR 31 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



48801 APR - 17

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06960

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Richard Watson			2a DATE OF DEATH MONTH DAY YEAR March 30, 1987		2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR December 14, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Dundalk	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8234 North Boundary Rd. Apt. B		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Operator 12b. KIND OF BUSINESS OR INDUSTRY Vulcan Materials		
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 8234 North Boundary Rd Apt B 21222	
14 FATHER'S NAME FIRST MIDDLE LAST Walter Watson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Johns			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT ADDRESS Evelyn Watson Same as 13e.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 11-5, 19 84, to July 10, 19 85, that (I) (we) last saw the deceased alive on July 10, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Marcos Levine MD		DEGREE		22c. DATE SIGNED 3/30/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARCOS Levine MD		22e ADDRESS 201 W. Wise Ave. Dundalk Md 21222			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4-3-87	23c. NAME OF CEMETERY OR CREMATORY Westview Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise ave. Balto Md 21222			25a. DATE REC'D BY REGISTRAR MAR 31 1987 25b. REGISTRAR'S SIGNATURE John Davidson		



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and page 2, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 06951  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED L. MIDDLE LAST WEBB			2a. DATE OF DEATH MONTH DAY YEAR MARCH 1987		2b. HOUR 4 P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 30, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CO. MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2408 CIDER MILL ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DEPT. OF SOCIAL SERVICE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.	13b. COUNTY BALTO. CO.	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2408 CIDER MILL RD. 21234	
14. FATHER'S NAME FIRST JOHN MIDDLE LAST KLEINSMITH		15. MOTHER'S MAIDEN NAME FIRST ISABEL MIDDLE LAST MONTGOMERY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-60-1070		17. INFORMANT FAMILY RECORDS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic obstructive DUE TO, OR AS A CONSEQUENCE OF lung disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 + 40
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--------------------------------------------------------

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hypertension					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/12/87 to 3/6/87, that (I) (we) last saw the deceased alive on 2/26/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE William J. Penner		DEGREE MD		22c. DATE SIGNED 5/5/87	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM PENNER		23c. ADDRESS 3222 St. Paul St. Baltimore, Md. 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 3-10-1987	23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CREM.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY, MD.
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 13 1987	
		25b. REGISTRAR'S SIGNATURE L. J. Anderson	





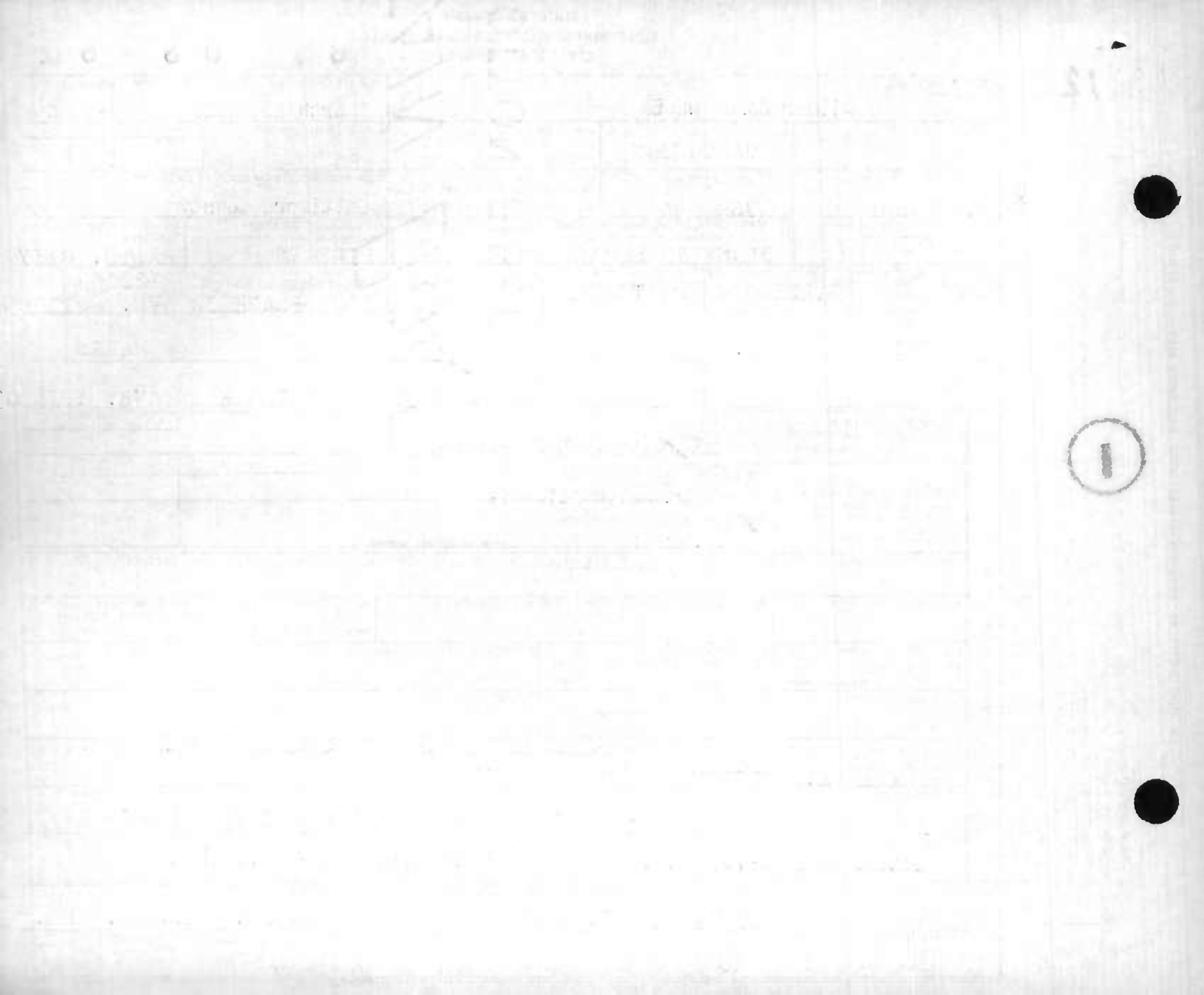
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87		06		96		2	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilmer John WEBER				2a. DATE OF DEATH MONTH DAY YEAR March 23, 1987				2b. HOUR 4:58a M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 09 16 02		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIREMAN		12b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND BALTIMORE				13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1000 FRANKLIN AVE. APT 1103 21221	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN L. WEBER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE HARES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 218328105		17. INFORMANT ADDRESS WANDA WEBER 1000 FRANKLIN AVE. APT 1103			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metabolic Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE 15									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 22</u> , 19 <u>87</u> , to <u>March 23</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 23</u> , 19 <u>87</u> , and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE DEGREE <u>Denise E.G. Coyle MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. DATE SIGNED 3-23-87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Denise E.G. Coyle, M.D.									
22e. ADDRESS 9000 Franklin Square Dr., 21237									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL									
23b. DATE 03/26/87									
23c. NAME OF CEMETERY OR CREMATORY OAKLAWN									
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD.									
24. FUNERAL DIRECTOR NAME ADDRESS <u>John</u> 1211 <u>Chesapeake Ave.</u>									
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 24 1987									

BP



049056 APR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

06963

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Gustav		W.		Wedeman				3		28		87				2:10 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS							
Male		White		10 29 04		82		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.				Baltimore County										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Towson		Meridian Multi Medical		Baker		Owner											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE									
Maryland		Balto.		Towson				8301 Carrbridge Circle		21204							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
Ferdiand		Wedeman		Wilhemina		Aschenback											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS											
No		219-32-0618		Mrs. Helen J. Wedeman		Same as 13e											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asperation Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a		Dry gangrene, Renal Failure, Anemia															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 28</u> 19 <u>87</u> to <u>March 28</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>March 28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Patricia A. Savadel, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/30/87</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Dr. Patricia A. Savadel		7600 Osler Dr.		21204													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		4/1/87		Loudon Park Cemetery		Balto.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Ruck Towson Funeral Home, Inc.		1050 York Rd.		21204		APR - 1 1987		Julia Davidson-Randall									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from this form. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) MINNIE K. WEINER					2a. DATE OF DEATH MONTH DAY YEAR MARCH 25, 1987		2b. HOUR 10:15 PM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC. 18, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER		12b. KIND OF BUSINESS OR INDUSTRY ACCOUNTING		
13a. STATE MARYLAND					13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM KLEINMAN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE TOOR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-52-7776		17. INFORMANT ADDRESS 21207 MRS. MARIAN NITA COWEN 7307 ROCKRIDGE RD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3-11-</u> 19 <u>85</u> , to <u>3-25</u> 19 <u>87</u> , that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <u>3-17</u> 19 <u>87</u> , and that in (my <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) ( <input type="checkbox"/> ) ( <input type="checkbox"/> ) view the body after death.										
22b. SIGNATURE <u>Harold B. B.</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/27/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold B. B.				22e. ADDRESS 7220 Park Heights 21208						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/27/87		23c. NAME OF CEMETERY OR CREMATORY ADATH YESHURUN CEM		23d. LOCATION BALTIMORE MARYLAND STATE				
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215				25a. DATE REC'D. BY REGISTRAR MAR 31 1987		25b. REGISTRAR'S SIGNATURE <u>William R. Randle</u>				

FOX COTTON FIBRE

WINTER 1911

1911

PRINTED AT THE  
OFFICE OF THE  
DIRECTOR OF AGRICULTURE  
WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06965	
1. DECEASED NAME (TYPE OR PRINT) SARAH WEINSTEIN					2a. DATE OF DEATH MONTH DAY YEAR MARCH 18, 1987			2b. HOUR 4:15 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 14, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT/MORE COUNTY MD.					
10. CITY OR TOWN OF DEATH PIKEVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JEWISH CONVAL. CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE.		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. CITY OR TOWN BALTO		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 4205 ST. VINCENTS DR. #21215					
14. FATHER'S NAME FIRST MIDDLE LAST ISRAEL MENDELSTAM				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216-32-3794		17. INFORMANT MR. MICHAEL CANTOR 5413 DAYWALT AVE. BALTO., MD 21206							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/28/80, to 3/18/87, that (I) (we) last saw the deceased alive on 3/16/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Ian Sunshine, MD.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IAN SUNSHINE, MD						22e. ADDRESS 6210 K. H. Ave BALTIMORE, MD 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 20, 1987		23c. NAME OF CEMETERY OR CREMATORY OHEL YAKOV			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)						25a. DATE REC'D. BY REGISTRAR MAR 24 1987		25b. REGISTRAR'S SIGNATURE Julia Swinson-Rodgers			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove card papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as item 18, sheet only injury, or other traumatic event, the medical examiner must be notified in advance.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) <b>MABELLE</b>				2a. DATE OF DEATH <b>03 16 87</b>			
3. SEX <b>FEMALE</b>				5. DATE OF BIRTH <b>MAY 8, 1900</b>			
4. RACE <b>WHITE</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
8. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>			
10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			
11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
13a. STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>SYKESVILLE</b>			
14. FATHER'S NAME <b>LOUIS B. NEWELL</b>				15. MOTHER'S MAIDEN NAME <b>ANNA S. STAGGE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>244-54-7159</b>			
17. INFORMANT <b>WILLIAM A. WEISE</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
19. ADDRESS <b>SAME AS # 13</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHF</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CHF @ Cardiac dysrhythmias</b>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
21a. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
22a. I certify that I (this hospital) attended the deceased from <b>3/15/87</b> to <b>3/16/87</b> , that I (we) lost saw the deceased alive on <b>3/16/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.				22c. DATE SIGNED <b>3/16/87</b>			
22a. SIGNATURE <b>M. Elmon</b>				22b. ADDRESS <b>RANDALLSTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>3/19/87</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>				23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>			
24. FUNERAL DIRECTOR <b>LEROY M. &amp; RUSSELL C. WITZKE</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1987</b>			
25b. REGISTRAR'S SIGNATURE <b>John Burden-Randall</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 48 shows any injury, or other traumatic cause, the medical examiner must be notified and a post-mortem examination must be made.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Jane WHEELLEY					2a. DATE OF DEATH MONTH DAY YEAR March 19, 1987			2b. HOUR 8:35a M	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 30, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Franklin Sq. Hospital				12a. USUAL OCCUPATION (TYPE OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR Steel Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Essex					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1000 Franklin Ave. Apt 1205 21221		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Meyer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Yeaker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Harry M. Wheeley, Husband			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest, cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Collapse of left lung</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <u>Thoracic aortic aneurysm</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>March 15, 1987</u> to <u>March 19, 1987</u> , that (we) lost saw the deceased alive on <u>March 19, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (do) (not) view the body after death.									
22b. SIGNATURE <u>H. Elnahal, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3/19/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hany Elnahal, M.D.				22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3/23/87		23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		23d. LOCATION City or Town County STATE Belair, Md.			
24. FUNERAL DIRECTOR NAME Bruzdzinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR MAR 20 1987		25b. REGISTRAR'S SIGNATURE <u>Jane Barker</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon from pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 06763		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERNON L. WHITE, Jr.					2a. DATE OF DEATH MONTH DAY YEAR 3 6 87			2b. HOUR 0655 M.				
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 28 40		6 AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Annapolis Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Md.						
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed			12b. KIND OF BUSINESS OR INDUSTRY -			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8305 Hilmar Ct. 21207	
14 FATHER'S NAME FIRST MIDDLE LAST VERNON L. White Sr.					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Prudence Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. - 220-360607		17 INFORMANT ADDRESS CARRIE E. White 8305 Hilmar Ct.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease										4 years		
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 4/25/83, 19, to 7/25/86, 19, that (I) (we) lost saw the deceased alive on 7/25/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												
22b. SIGNATURE Julius C. Gluck, M.D.					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/7/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julius C. GLUCK, M.D.					22e. ADDRESS 3671 OFFUTT Rd Randallstown, Md 21133							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/11/87		23c. NAME OF CEMETERY OR CREMATORY Carpenters Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Severna Pt. Md.				
24. FUNERAL DIRECTOR NAME W.C. March F/H West 4300 Wabash Ave.					25a. DATE REC'D BY REGISTRAR MAR 09 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 06769

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
SHERI		Ann		WILKERSON		3 13 1987				M					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				7d. HOUR	
F	W	7/4/69		17 YRS.						3 14 1987				12:01 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
MD		USA		Baltimore County MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Cockeysville		York Rd. so. of Phoenix Rd.				Student				College					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD		BALTO.		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1307 Gittings Ave., 21239							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Theodore		T. Wilkerson		Carol		Ann Lippy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS					
No				220 02 7400		Carol A. Wilkerson,				Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a): <u>Cranio-cerebral trauma</u>															
8151															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				1:30 M. 3-13- 1987				Passenger of van/fixed object impact.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
				road				York Rd. so. of, Cockeysville, Balto. MD							
				Phoenix Rd.											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
				M.D. Assistant				MEDICAL EXAMINER				3-14-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
William M. Zane, M.D.				111 Penn St., Balto., MD				21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Cremation				3/18/87		Green Mount				Balto., MD					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Henry W. Jenkins & Sons Co.				MAR 16 1987				Alicia Davidson-Russell							
4905 York Road Balto., MD				21212											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 (AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH) WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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College of Education

1000 10th St., N.W., Wash., D.C.

Dr. W. H. Rouse Evans, Director, Bureau of Education for the Handicapped

Washington, D.C.



U.S. Department of Education  
Bureau of Education for the Handicapped  
Washington, D.C.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE REMAINS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

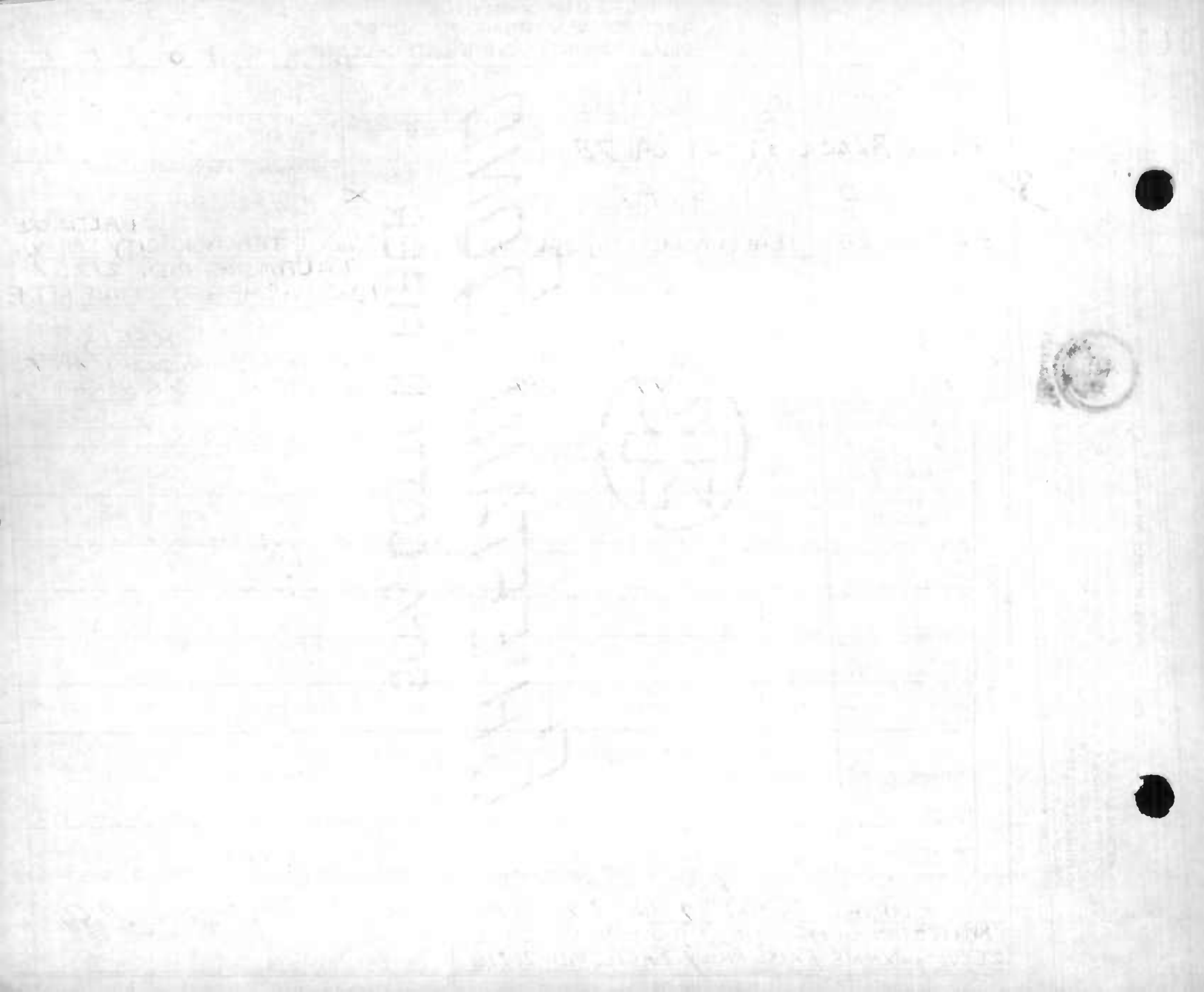
REG. NO. 06970

1. DECEASED NAME (TYPE OR PRINT)			FIRST Gertrude			MIDDLE Wilkins			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH 3			DAY 24			YEAR 1987			2b. HOUR 6:48 P.M.						
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 01		DAY 01		YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			MONTH 3			DAY 24			YEAR 1987			2d. HOUR 1:18 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD																		
10. CITY OR TOWN OF DEATH BALTIMORE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CO., GENERAL HOSP.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL TEACHER				12b. TYPE OF BUSINESS CITY SCHOOLS												
13a. STATE MARYLAND										13b. COUNTY BALTO		13c. CITY OR TOWN BALTIMORE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS BALTIMORE, MD. 21207 10 CEDAR HEIGHTS COURT APT. F												
14. FATHER'S NAME FIRST WILLIAM				MIDDLE A.		LAST STANLEY				15. MOTHER'S MAIDEN NAME FIRST ALICE				MIDDLE KEELY		LAST														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 217-20-3734				17. INFORMANT BALTIMORE, MD. 21207 APT. F. STANLEY BECKETT 10 CEDAR HEIGHTS CT.																						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																														
ACTUAL SIGNATURE E. P. Williamson Jr.				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 3/24/87																		
EXAMINER'S NAME (TYPE OR PRINT) E. P. Williamson Jr.				ADDRESS 5550 BALTO. NAT'L PK 21228																										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3/30/1987				23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PK				23d. LOCATION CITY OR TOWN BALTIMORE COUNTY STATE MD																		
24. FUNERAL HOME OR NAME NORTON & SONS FUNERAL HOME, INC.				ADDRESS 2501 GWYNNS FALLS PKWY. BALTO, MD, 21216				25a. DATE REC'D. BY REGISTRAR MAR 26 1987				25b. REGISTRAR'S SIGNATURE																		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed with the health department. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) <b>ARTHUR EDWARD KILKOFF</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Mar 14 87</b>		2b. HOUR MIN. <b>4:15 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 22, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> COUNTY <b>XXX</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11 SLADE AVE., APT. 316 XXXXXX</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL CO.</b>		
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>285-10-8319</b>		17. INFORMANT ADDRESS <b>SHALE STILLER 300 E. LOMBARD ST. (21202)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Biliary crisis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bile duct carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>3 mo.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <b>did</b> attend the deceased from <b>March 13</b> , 19 <b>87</b> , to <b>March 14</b> , 19 <b>87</b> , that (I) <b>last</b> saw the deceased alive on <b>March 13</b> , 19 <b>87</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>has</b> (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/14/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Andrew P. Weinfeld, MD</b>					22e. ADDRESS <b>222 W. Calverton Ave, Balt. Md 21210</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>3/17/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW MEMORIAL PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>					25a. DATE REC'D BY REGISTRAR <b>MAR 24 1987</b>					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06972

1 - FOR STATE REGISTRAR		2a DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS.		7b. DATE OF DEATH MONTH DAY YEAR		7b. HOUR P			
		Bessie Williams		Female		White		10 26 01		85		3 31 87		9:50 P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Scranton		USA				Baltimore County MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Catonsville		Inglenook Nursing Home		Homemaker													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Md		Balto.		Catonsville				230 Altamont Ave		21228							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Herbert R. Highman		Nora Sherwood															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS											
No		215-48-4249		Ann Miller		230 Altamont Ave		21228									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old age</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Two days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): <u>Pres. urinary tract infection, senile dementia</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>10/85</u> , 19 <u>—</u> , to <u>3-31-87</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>3-31-87</u> , 19 <u>—</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED											
<u>[Signature]</u>		M.D.				04-01-87											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Allan Perez M.D.		1009 Frederick Rd		21228													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		4/3/87		Forest Hill Cemetery		Scranton Penn.											
24. FUNERAL DIRECTOR HARRY H WITZKE & FAMILY 4112 OLD COLUMBIA PIKE FUNERAL HOME, INC., ELLICOTT CITY, MD 21043														25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
														APR = 2 1987		<u>[Signature]</u>	

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

HARRY M. RITZKE & FAMILY, 4115 OLD COLUMBIA PIKE  
FURNACE, INC., ELLICOTT CITY, MD 21043

WEST FOREST HILL Cemetery, Baltimore

Phone

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 06973	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Carl Julius Wilmas</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 21, 1987</b>		2b. HOUR MIN. <b>5:16 AM</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 21, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co., MD.</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holly Hill Manor</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Freight Mgr. .</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Erie R.R.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Lutherville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1619 Charmuth Road Lutherville 21093</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Wilmas</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Fuchs</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW I 706 10 0359</b>	17. INFORMANT ADDRESS <b>Dr. Betty W. Robinson 805 Stevenson Ln.-04</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HTN.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>C.A.D.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <b>Feb 12, 1987</b> , to <b>3/23/87</b> , that (I) (we) last saw the deceased alive on <b>Feb 12, 1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (aid) (did not see the body after death).					
22b. SIGNATURE <b>Stephen LAIKEN</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/23/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen LAIKEN</b>		22e. ADDRESS <b>6505 YORK Rd. 21212</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/1/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Louis Missouri</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>

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www.fishbase.org

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section page 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.  
IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 06974

1. DECEASED NAME (TYPE OR PRINT) <b>Regina A. Windsor</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 13 1987</b>		2b. HOUR <b>1938 M</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 15 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Pikesville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Austin R. Dryden</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith E. Jones</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-09-1512</b>		17. INMATE ADDRESS <b>Mr. Clifford E. Dryden</b> <b>8827 Orchard Road Pikesville Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordic Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ascend</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Bronchial Asthma</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-22</b> , 19 <b>83</b> , to <b>3-5</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3-5-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.					
22b. SIGNATURE <b>Sh BHA TIAVI</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/16/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sh BHA TIAVI</b>		22e. ADDRESS <b>5015 Rose Lane Rd Belts Md 20705</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/17/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc.</b> <b>8728 Liberty Road Randallstown, MD. 21133</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAR 16 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Sh BHA TIAVI</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 with this would be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Alberta B. WINTERLING</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 17, 1987</b>			2b. HOUR <b>9:00a M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 7 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville 21237</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Sq. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Essex</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>509 N. Stuart Ave. 21221</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Goodwin</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary ?</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214 74 5843</b>		17. INFORMANT <b>Ruth Orr, Daughter</b>			ADDRESS <b>305 Oberle Ave. Balto., Md. 21221</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe left ventricular dysfunction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 9</b> , 19 <b>87</b> , to <b>March 17</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>March 17</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alfred Covington</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>3/17/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alfred Covington, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Dr., Balto., 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (IF BURIAL) <b>Burial</b>		23b. DATE <b>3/20/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Prudzinski Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



U. S. A.

Female white 1 June 1905

Altitude, 25,000 ft.

Locality, 11,000 ft. altitude

1000 ft. altitude

Charles Goodwin

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

1000 ft. altitude

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and file it in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, it must be examined by a medical examiner.

048342 MAR 17

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06976

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BESSIE MADORA WISNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 23 87</b>		2b. HOUR <b>10:40 A.M.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 22 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>98</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Home (Catonville)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		13a. STREET ADDRESS / ZIP CODE <b>314 WESTSHIRE ROAD 21229</b>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. CITY OR TOWN <b>CATONSVILLE</b>	
13d. STATE <b>MARYLAND</b>		13e. COUNTY <b>BALTIMORE</b>		13f. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13g. STREET ADDRESS / ZIP CODE <b>314 WESTSHIRE ROAD 21229</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>REUBEN BOHN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SUSAN ALICE WEANT</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-22- 4136</b>	
16c. ADDRESS <b>ROBERT E. LEPSON 5639 Oakland Rd. 21227</b>		17. INFORMANT <b>ROBERT E. LEPSON</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic CVD, advanced</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <b>10/23</b> , 19 <b>81</b> , to <b>3/23</b> , 19 <b>87</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>3/23</b> , 19 <b>87</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If not, check ( ) and do not view the body after death.)							
22b. SIGNATURE <b>Herbert J. Levickas</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/24/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HERBERT J. LEVICKAS, MD.</b>		22e. ADDRESS <b>5404 EAST DRIVE</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			
23b. DATE <b>3/26/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOW BRANCH CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WESTMINSTER CARROLL MD.</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove column 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87		REG. NO. 06977					
1. DECEASED NAME (TYPE OR PRINT) <b>Delores Wilt</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3-10-1987</b>		2b. HOUR <b>1:17 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-25-1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Carney</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9613 10th Ave. 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis H. Wanner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virgie M. Moylan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-14-5478</b>		17. INFORMANT ADDRESS <b>Mr. John Wilt - Same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute RESPIRATORY Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>STATUS EPILEPTICUS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>2 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Arteriosclerotic Vascular Disease, Gastroscopy, Alzheimers Dementia</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (we) (this hospital) attended the deceased from <b>1986</b> , to <b>3-10-1987</b> , that (we) last saw the deceased alive on <b>3-10-1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.									
22b. SIGNATURE <b>GARY A. MANKO</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-10-1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY A. MANKO</b>				22e. ADDRESS <b>Suite 5, 11 E Chestnut Hill Ln, Reisterstown MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>3-10-87</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>State Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia T. ...</b>	

BP

(A)

1971 8 1 1444

DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR									
Helen		E		Woods				3		28		87		6:20		p.m.									
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)				7a. IF UNDER 1 YEAR				7b. IF UNDER 1/4 HRS.									
Female		Cauc.		2 MONTH 05 DAY 02 YEAR				85 YRS				MONTHS				DAYS									
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH																	
Philadelphia, Pa.		US						Baltimore Co. MD.																	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY															
Cockeysville		Broadmead				Social Worker				University															
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE																			
MD		Baltimore		Baltimore		116W. University Parkway 21210																			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																					
George W Woods				Anna M Lamon																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS													
No				220-30-1611				933				Gilbert Road													
								Ms. Marian Woods				Cheltenham, Pa.													
18 CAUSE OF DEATH (Enter only one cause probable for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																									
IMMEDIATE CAUSE (a) RESPIRATORY ARREST																									
DUE TO, OR AS A CONSEQUENCE OF																									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																									
DUE TO, OR AS A CONSEQUENCE OF																									
(c)																									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
								YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
				HOUR A.M. MONTH DAY YEAR																					
				P.M. 19																					
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION																	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								STREET				CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																									
22b. SIGNATURE																DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
Walter H. Jones, M.D.																				3/30/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY STATE									
Removal				3-28-87								CITY OR TOWN													
24. FUNERAL DIRECTOR																25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME																APR 01 1987		Julia T. Jones-Randall							
State Anatomy Board																ADDRESS		Balto., Md.							

BP\_\_\_\_\_

25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
APR 01 1987	Julia Davidson-Rendall

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Page 10 of 10

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on 10/1/10

4/9



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>ANNETTE Elizabeth WRIGHT</b>					2a. DATE OF DEATH MONTH <b>03</b> DAY <b>19</b> YEAR <b>'87</b>		2b. HOUR M <b>AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH <b>Nov.</b> DAY <b>19</b> YEAR <b>1951</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>35</b>		7. IF UNDER 1 YEAR MONTHS <b>YRS.</b> DAYS <b>HOURS</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GPMC-6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Youth Super.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Harford</b> 13c. CITY OR TOWN <b>Abingdon</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2839 Gates Head Ct. 21009</b>		
14. FATHER'S NAME FIRST <b>Harold</b> MIDDLE <b>Meeks</b> LAST <b>Elizabeth</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Hisley</b> LAST <b>Hisley</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-60-1419</b>		17. INFORMANT <b>Abingdon, Md. 21009</b> <b>Michael Wright, 2839 Gates Head Ct.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <b>CARDIOVASCULAR ARREST</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF <b>SEPSIS</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASPERGILLOSIS PNEUMONIA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>02/02</b> , 19 <b>87</b> , to <b>03/19</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3/19</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>K. Golnik</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>03/19/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. GOLNIK, M.D.</b>				22e. ADDRESS <b>GPMC-6701 N. CHARLES ST.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Mar. 23, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY STATE <b>Md.</b>			
24. FUNERAL DIRECTOR <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b> <b>6009 Harford Rd., Balto., Md. 21214</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 23 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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SUBJECT

RECEIVED

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47762 MAR 20 1987

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 6 9 8 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Augustus M. Wright			2a. DATE OF DEATH MONTH DAY YEAR 03 17 87			2b. HOUR M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 26 29		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.				
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.			12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) Steel worker		12b. KIND OF BUSINESS OR INDUSTRY Steel Ind.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto		13c. CITY OR TOWN Turner Sta.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 130 Wm. Wade Way 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Junius B. Wright			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Vaughter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 51--53		17. INFORMANT ADDRESS Lillian E Wright 130 Wm Wade Way					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M. T. M.D. M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-18-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mohammed Tagi, M.D.						22e. ADDRESS 1576 Merritt Blvd. St. 23 Balto. Md 21202				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/21/87		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Pk. Laurel		23d. LOCATION CITY OR TOWN COUNTY STATE Md.			
24. FUNERAL DIRECTOR NAME James A. Morton & Sons FbH. 1701 Laurens						25a. DATE REC'D. BY REGISTRAR MAR 19 1987		25b. REGISTRAR'S SIGNATURE [Signature]		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. When please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above, the cause of death, or other traumatic event, the medical examiner must be notified at once.

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Salisbury County

General

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

D 6 9 8 1  
4 45 P.M.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
OSCAR		E.		WURZBERGER, Sr.	3	126	87		4 45 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 72 HRS		
MALE	CAUCASIAN	MONTH DAY YEAR 6/ 4 89		97 YRS	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Germany	U. S. A.			Baltimore County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Catonsville	Meridian Health Care Home		Self Employed-Millworker						
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE					
Md.		Balto.		Balto., Md. 1729 Wilmington Ave. #21230					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Charles O.		FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		220-12-7334		124 Crest Avenue - Glen Burnie, Md. Oscar E. Wurzberger, Jr. #21061					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE - PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE CENTRAL VASCULAR</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>INSUFFICIENCY</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>NO</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 19 <u>83</u> , to <u>MARCH</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>MARCH 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
<u>[Signature]</u>		<u>MD</u>		<u>3/26/87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<u>G. Truman Schwab</u>		<u>3312 Frederick Ave. #21229</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		Mar. 28, 1987		Meadowridge Cemetery		CITY OR TOWN COUNTY STATE Howard Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>G. Truman Schwab</u>		<u>APR - 1 1987</u>		<u>[Signature]</u>					

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "While at work" only injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 06982

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	MIN.
MATTHEW				FREDERICK YENNEY	03	02	'87		7:15P	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE	Caucasian	MONTH 10 DAY 25 YEAR 1893		93	MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Pennsylvania	U.S.A.			BALTIMORE COUNTY		MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON	GEMC-6701 N. CHARLES ST.		Supervisor		Steel					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE				
13a. STATE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		608 East 7th Ave.		15084		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
FIRST		MIDDLE	LAST	FIRST		MIDDLE	LAST			
Matthew		F.	Yenney	Matilda		Hundertmark				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (son)		ADDRESS				
Yes		WW II		193-07-0472		Thomas M. Yenney		24 Grupowder Road Glen Arm, MD 21057		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) PRIMARY LUNG CANCER WITH BRAIN METASTASES										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2/23, 19 87, to 3/02, 19 87, that (I) (we) last saw the deceased alive on 3/02, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE L. Kauffman M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/02/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. KAUFFMAN, M.D.		22e. ADDRESS GEMC-6701 N. CHARLES ST.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		5 Mar 87		Greenwood Memorial Park		Mausoleum, Lower Burrell, PA				
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
				MAR 09 1987		Julia Dindon-Budue				

MEDICAL CERTIFICATION

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UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 7 0 6 9 8 3

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1- DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		9:20 A.M.	
Harry L. Young		3-1-87			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	9-26-1915	71	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	U.S.A.		Balto. Co. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Cub Hills	9504 Old Harford Rd.		Ret. Superintendent		Construction
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?		
13b. STATE 13c. CITY OR TOWN			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md. Balto. Balto.			13e. STREET ADDRESS / ZIP CODE		
			9504 Old Harford Rd. 21234		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
George Young		Elizabeth Gerlack			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214-03-2897		Melba Young, Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Lung Cancer					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) Liver Failure 2" to Lung Cancer					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/15, 19 57, to 2/27, 19 87, that (I) (we) last saw the deceased alive on 2/27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Mark R. Stomberg MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Mark R. Stomberg, MD.		7600 Osler Dr.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		3-2-87		Westview	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc., 5305 Harford Rd.		MAR 02 1987		E. J. Ruck	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC'D NO. 6 9 8 4

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF DEATH			2c. DATE PRONOUNCED DEAD			2d. HOUR		
James A. Young			3. SEX Male			4. RACE White			5. DATE OF BIRTH 10 26 01			6. AGE (IN YEARS) 85 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD			10. CITY OR TOWN OF DEATH Landsdown		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3231 Rosalie Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman			12b. KIND OF BUSINESS OR INDUSTRY Revere Copper & Brass			13a. STATE Maryland			13b. COUNTY Baltimore		
13c. CITY OR TOWN Lansdowne			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3231 Rosalie Road			13f. ZIP CODE 21227			14. FATHER'S NAME UNKNOWN		
15. MOTHER'S MAIDEN NAME UNKNOWN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-10-0244			17. INFORMANT Charles E. Shipley			17. ADDRESS 3231 Rosalie Rd. 21227		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Pulmonary Emphysema</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion					
ACTUAL SIGNATURE <u>Charles P. Kokes</u>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 3/8/87	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn St.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/10/87		23c. NAME OF CEMETERY OR CREMATORY Security Process Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore Md.	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave,				25a. DATE REC'D. BY REGISTRAR MAR 11 1987		25b. REGISTRAR'S SIGNATURE Deborah R. Roesch	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

20% COTTON FIBER

MADE IN U.S.A.

DMO



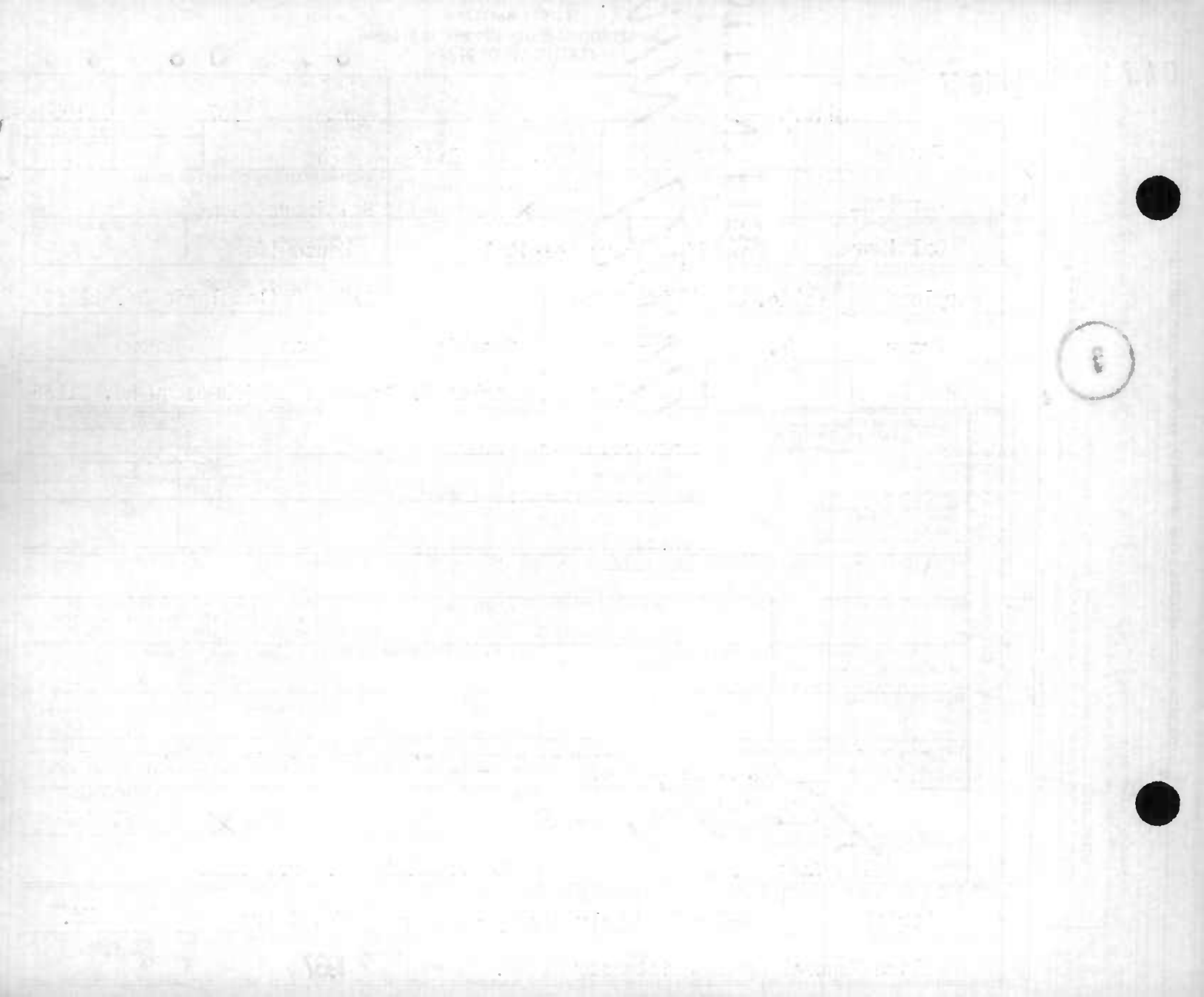
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained for 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, place 1 card in each box and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
REG. NO. 06985									
1. DECEASED NAME (TYPE OR PRINT) Mildred E. ZABOROWSKI					2a. DATE OF DEATH MONTH DAY YEAR March 12, 1987			2b. HOUR 11:05pM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 21 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN White Marsh		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 11540 Philadelphia Rd. 21163	
14. FATHER'S NAME FIRST MIDDLE LAST Peter T. Graber					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia Anna Brown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-30-1814		17. INFORMANT ADDRESS Charles E. Graber 402 Highmeadow Rd. 21136					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pericarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (H) (this hospital) attended the deceased from <u>March 10</u> , 19 <u>87</u> , to <u>March 12</u> , 19 <u>87</u> , that (H) (we) last saw the deceased alive on <u>March 12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Julin Tang</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 03/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julin Tang, M.D.					22e. ADDRESS 9000 Franklin Sq. Dr., 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-16-87		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home					ADDRESS Reisterstown, Md.		25a. DATE REC'D. BY REGISTRAR MAR 17 1987		
25b. REGISTRAR'S SIGNATURE									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

06986

1. DECEASED NAME (TYPE OR PRINT) <b>Paul ZACK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 6, 1987</b>			2b. HOUR <b>1:47 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 10 49</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>38</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. _____	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
12. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSPITAL</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		15. KIND OF BUSINESS OR INDUSTRY -----	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>MARYLAND</b> 16b. CITY <b>BALTIMORE</b> 16c. CITY OR TOWN <b>ROSEDALE</b> 16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 16e. STREET ADDRESS / ZIP CODE <b>1225 63rd St. 21237</b>									
17. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK JOSEPH ZACK</b>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>THERESA SWANK</b>						
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		19b. SOCIAL SECURITY NO. <b>219-58-7483</b>		19c. INFORMANT ADDRESS <b>FRANK ZACK 1225 63rd st.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anoxic encephalopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Probable encephalomeningomyelitis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (M) (this hospital) attended the deceased from <b>February 28</b> , 19 <b>87</b> , to <b>March 6</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>March 6</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alfonza Ruiz M.D.</b>				DEGREE <b>Alfonza Ruiz, M.D.</b>				22c. DATE SIGNED <b>3-6-87</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alfonza Ruiz, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>03/09/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. BALTO. MD.</b>			
24. FUNERAL DIRECTOR <b>Julia</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 09 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia</b>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR M	
Helen		A.		Zakowsky				March 11, 1987			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		January 30, 1920		67 YRS					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Dundalk		1718 Evergreen Drive						Retired		London Manufacturing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland				Baltimore		Dundalk		13e. STREET ADDRESS / ZIP CODE 1718 Evergreen Drive 21222			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Adam				Lutinsky				Katherine Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No				168-14-5995		Geraldine M. Sacilotto RD#1 Box 224 Delta, PA 17314					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholelithiasis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Ischemic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic Heart Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
				21g. I certify that (I) (this hospital) attended the deceased from <u>3-6-87</u> to <u>3-6-87</u> that (I) <u>did not</u> saw the deceased alive on <u>3-6-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>was not</u> (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/13/87			
22d. PHYSICIAN'S NAME		22e. ADDRESS									
VENTEDD ALIDU		6010 YORK RD 21212									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3-14-87		Sacred Heart of Jesus		Baltimore Maryland					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Duda-Ruck Funeral Home of Dundalk		7922 Wise Ave. Dundalk, MD 21222		MAR 18 1987		Julia Davidson-Ruckner					

BP

10/10/18

20% cotton fiber

10/10/18

10/10/18

10/10/18

10/10/18

10/10/18



10/10/18

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

06988

FOR  
1. STATE  
REGISTRAR

8 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH S. ZIES		2a. DATE OF DEATH MONTH DAY YEAR 3 2 87		2b. HOUR 450 <sup>M</sup>	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 26, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7617 Club Road, 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Spencer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Oswald		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 215 58 3723		17. INFORMANT ADDRESS William Trimble, Jr., Balto., MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebrovascular</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombosis and Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1-87</u> to <u>3-2-87</u> , that (I) (we) lost saw the deceased alive on <u>3-2-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A.H. Ghiladi</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-2-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A.H. GHILADI, MD.</u>		22e. ADDRESS <u>7600 OSLER Dr Towson 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/3/87	23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212			25a. DATE REC'D BY REGISTRAR MAR 04 1987		
25b. REGISTRAR'S SIGNATURE <u>John D. ...</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place this certificate in the box on page 4. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other funeral service. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wanda R. Zuebert						2a. DATE OF DEATH MONTH DAY YEAR 03 18 87			2b. HOUR M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 05 24 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ingelnook Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 210 Park Drive 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Rakowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kunizunda Schultz				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 212-07-2327B				17. INFORMANT Mr. Christopher A. Zuebert				ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Cholecystitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia - senile dementia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia - senile dementia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <u>3-12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Raafat Y. Girgis						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-20-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raafat Y. Girgis M.D.						22e. ADDRESS 500 North Rolling Road 21228					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-21-87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Mem Grdns			23d. LOCATION CITY OR TOWN COUNTY Timonium Balto. Anne Arundel Md.			
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home						ADDRESS 301 Frederick Rd.			25a. DATE RECEIVED BY REGISTRAR MAR 20 1987		
						25b. REGISTRAR'S SIGNATURE					



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